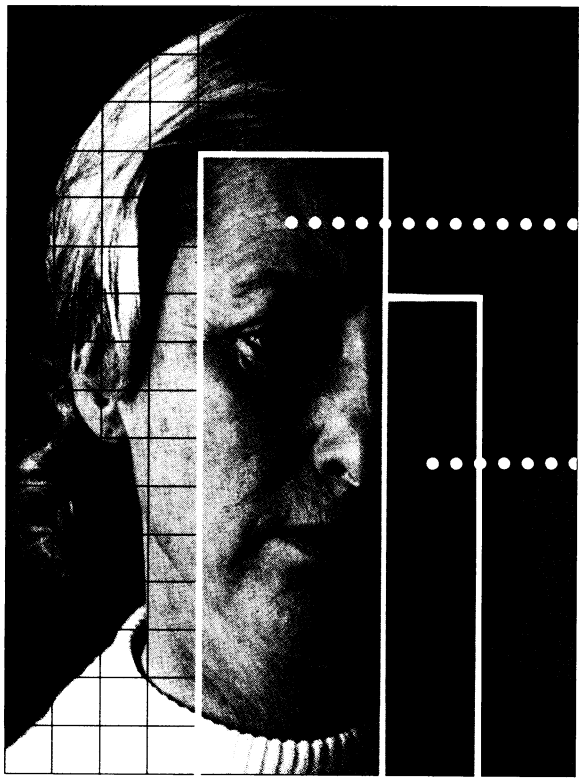
Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

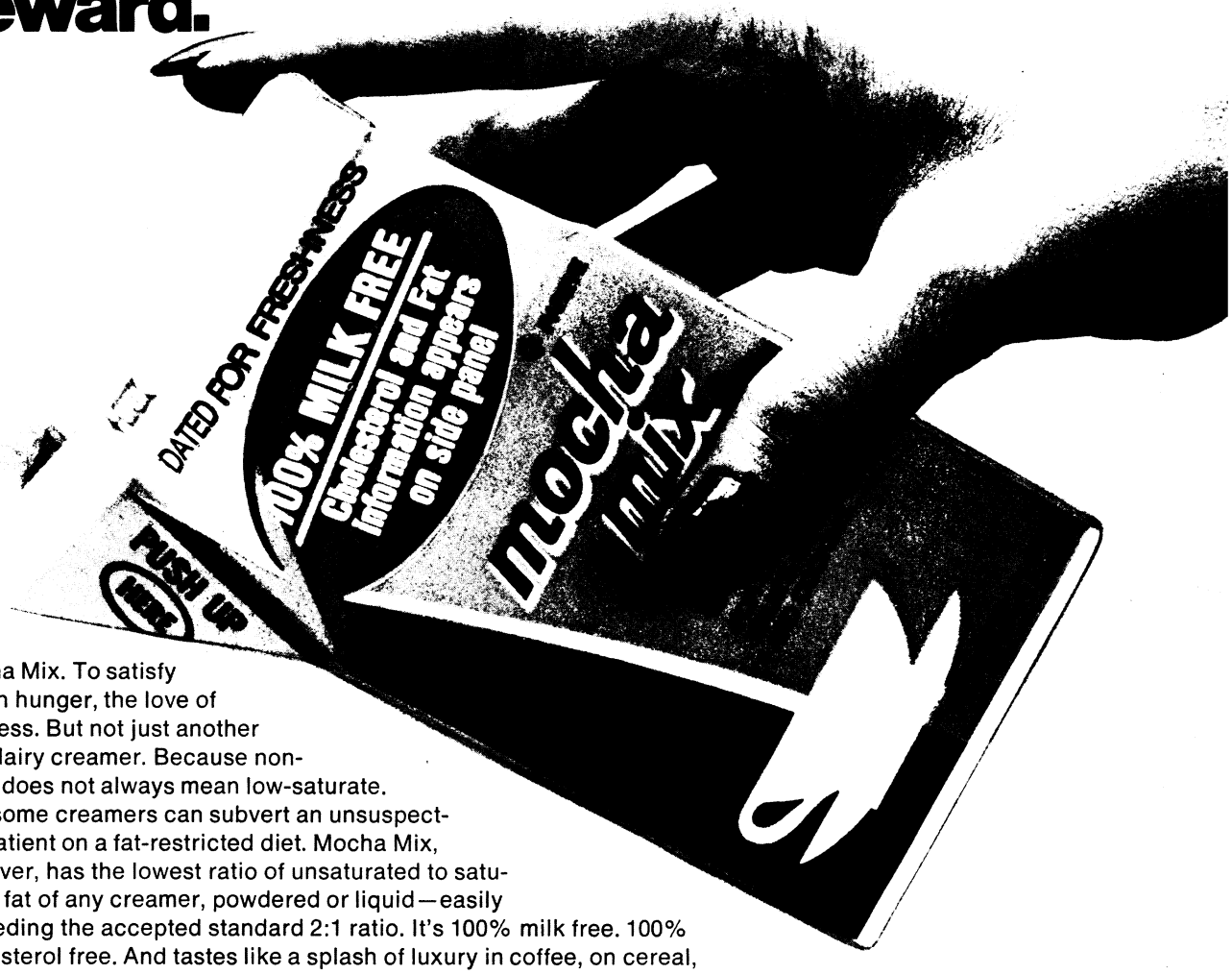
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

What to do when your patient feels robbed of milk, cream and saturated fat.

Offer a reward.



Mocha Mix. To satisfy mouth hunger, the love of richness. But not just another non-dairy creamer. Because non-dairy does not always mean low-saturate. And some creamers can subvert an unsuspecting patient on a fat-restricted diet. Mocha Mix, however, has the lowest ratio of unsaturated to saturated fat of any creamer, powdered or liquid—easily exceeding the accepted standard 2:1 ratio. It's 100% milk free. 100% cholesterol free. And tastes like a splash of luxury in coffee, on cereal, fruit, dessert, even in cooking. If you must deprive your patient, add a reward for good behavior. Mocha Mix.

MOCHA MIX DATA SHEET

Portion Size 1 Fluid Ounce (2 Tbs.)	
Servings per container	16
Calories	40
Protein	0 grams
Carbohydrate	3 grams
Fat	3 grams
Percent of Calories from Fat	73%
Polyunsaturated Fat	1 gram
Saturated Fat	0 grams
Cholesterol	0

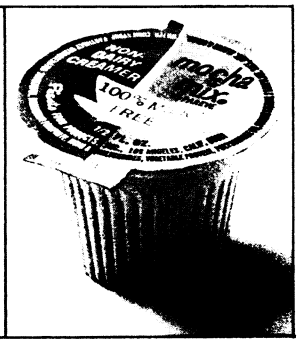
(Percentage of U.S. Recommended Daily Allowances (U.S., RDA)*

*Contains less than 2% of the U.S. RDA of Protein, Vitamin A, Vitamin C, Thiamine, Riboflavin, Niacin, Calcium, Iron.

In addition to the pint and quart size found in the dairy case of most grocery stores, Mocha Mix is available in 4 ounce and ½ oz. portion packs for hospitals and institutions.

Interested? Send us a note and we will send you a supply of coupons your patients can redeem at their grocers. Hospital service may also be supplied upon request. Mail to:

Mocha Mix Dept. Presto Food Products, Inc.
P.O. Box No. 21908, Los Angeles, Calif. 90021



mocha mix® ...the non-dairy creamer that's lowest in saturated fat.

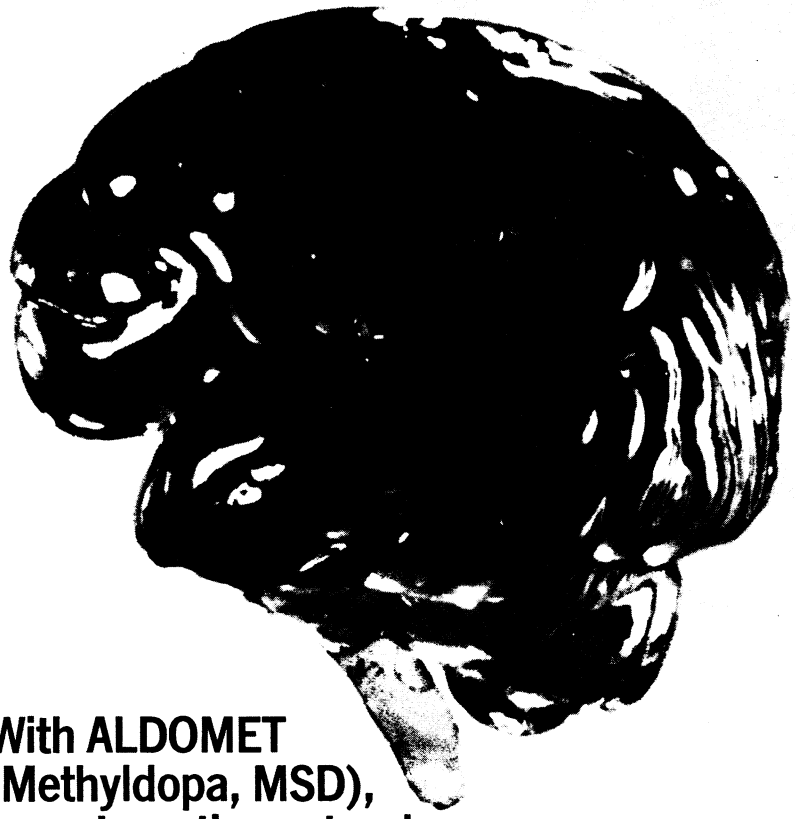
In hypertension, ALDOMET® (METHYLDOPA|MSD) usually offers more than effective lowering of blood pressure...

With ALDOMET (Methyldopa, MSD), existing renal function is usually unchanged

ALDOMET has no direct effect on renal function. When used in effective doses, ALDOMET usually does not reduce glomerular filtration rate, renal blood flow, or filtration fraction.

With ALDOMET (Methyldopa, MSD), cardiac output is generally unchanged

ALDOMET has no direct effect on cardiac function. When ALDOMET is used in effective doses cardiac output is usually maintained with no cardiac acceleration; in some patients the heart rate is slowed.



With ALDOMET (Methyldopa, MSD), symptomatic postural hypotension is infrequent

ALDOMET reduces both supine and standing blood pressure. Less frequent symptomatic postural hypotension is experienced with ALDOMET than with many other antihypertensive agents. Exercise hypotension and diurnal blood pressure variations rarely occur.

for hypertension

TABLETS, 250 mg, 500 mg, and 125 mg

ALDOMET®

(METHYLDOPA|MSD)

a unique antihypertensive agent

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders. It is not recommended in pheochromocytoma.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

MSD
MERCK SHARP & DOHME

For a brief summary of prescribing information, please see following page.

addendum

MSD
MERCK SHARP & DOHME

to further simplify therapy for many patients

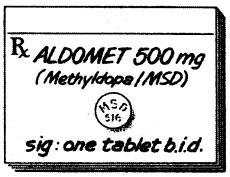
now available ALDOMET® 500 mg (METHYLDOPA|MSD)

- **often more practical to prescribe**
- **easier for patients to remember**

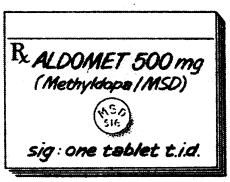
Now offered in addition to the standard 250-mg tablet, the new ALDOMET 500 mg tablet is a patient convenience. An especially important one, since in hypertension convenience of the dosage schedule is one factor that can make the difference in compliance of the patient. The minimum daily dose of ALDOMET is 250 mg b.i.d. The usual starting dose is 250 mg t.i.d. Dosage is adjusted as necessary by adding or deleting 250 mg or 500 mg at intervals of not less than two days. The maximum dose is 3.0 g per day.

Examples of b.i.d. or t.i.d. dosage convenience provided by ALDOMET 500 mg within the usual daily dosage range of 500 mg to 2.0 g:

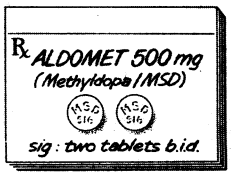
1.0-g daily dose =

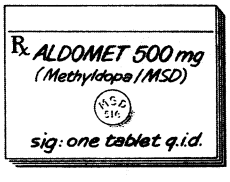


1.5-g daily dose =



2.0-g daily dose =



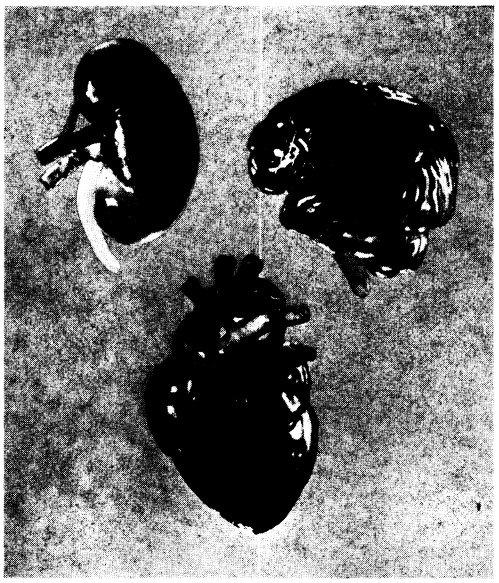


NOTE: Tablets shown are not actual size.

in hypertension

ALDOMET® (METHYLDOPA|MSD)

usually lowers blood pressure effectively



Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

MSD MERCK SHARP & DOHME

Saffola® is higher in polyunsaturates than Fleischmann's, Imperial or Mazola.

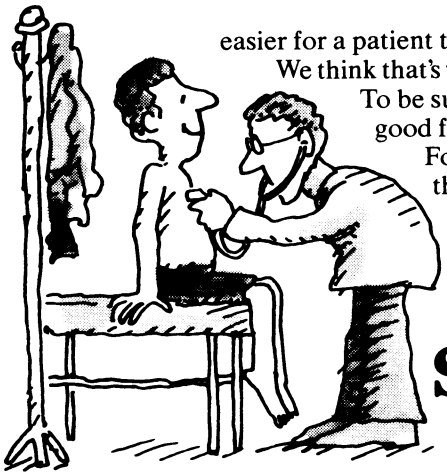
Shouldn't that difference make a difference in what you recommend?

Your patients on modified fat diets can't do better than Saffola. Of the leading margarines, Saffola is highest in polyunsaturates. And no other margarine is lower than Saffola in saturated fats. Because Saffola contains safflower oil—one of nature's most perfect foods. Safflower oil is higher in polyunsaturates than any vegetable oil, including corn oil.

But to your patients, Saffola's good taste is just as important as Saffola's nutrition. The flavor makes it easier for a patient to follow a low cholesterol diet.

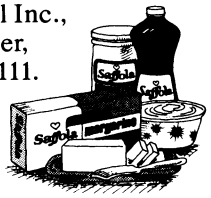
We think that's why Saffola is worth recommending.

To be sure your patients are eating what's good for them, and enjoying it.

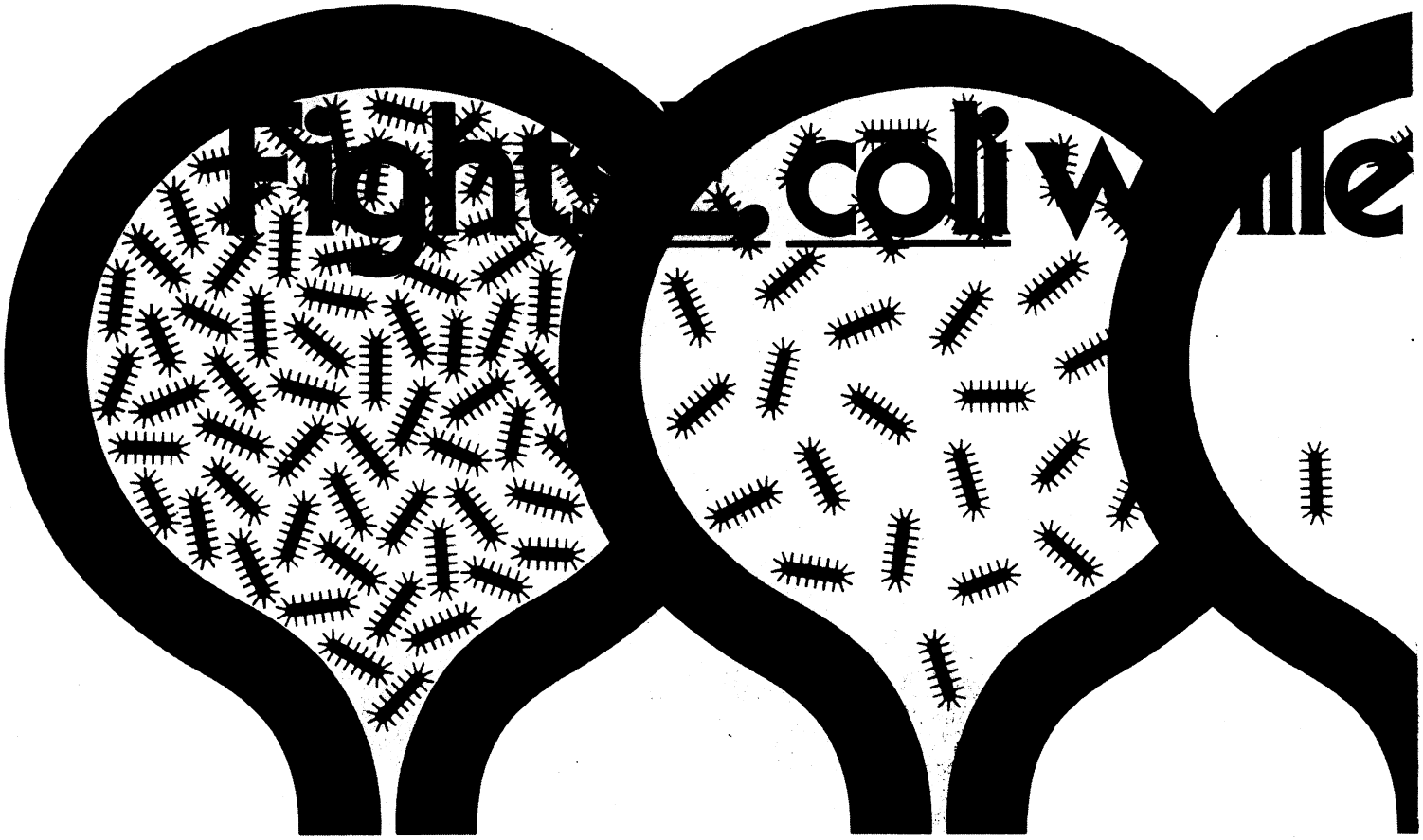


For comparative information about the nutritional benefits of Saffola, write Consumer Products Division, PVO International Inc., World Trade Center, San Francisco, 94111.

Saffola



Convenient B.I.D. Gantanol®
(sulfamethoxazole)



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. ***Note:*** **Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: *Systemic sulfonamides are contraindicated in infants under 2 months of age* (except adjunctively with pyrimethamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

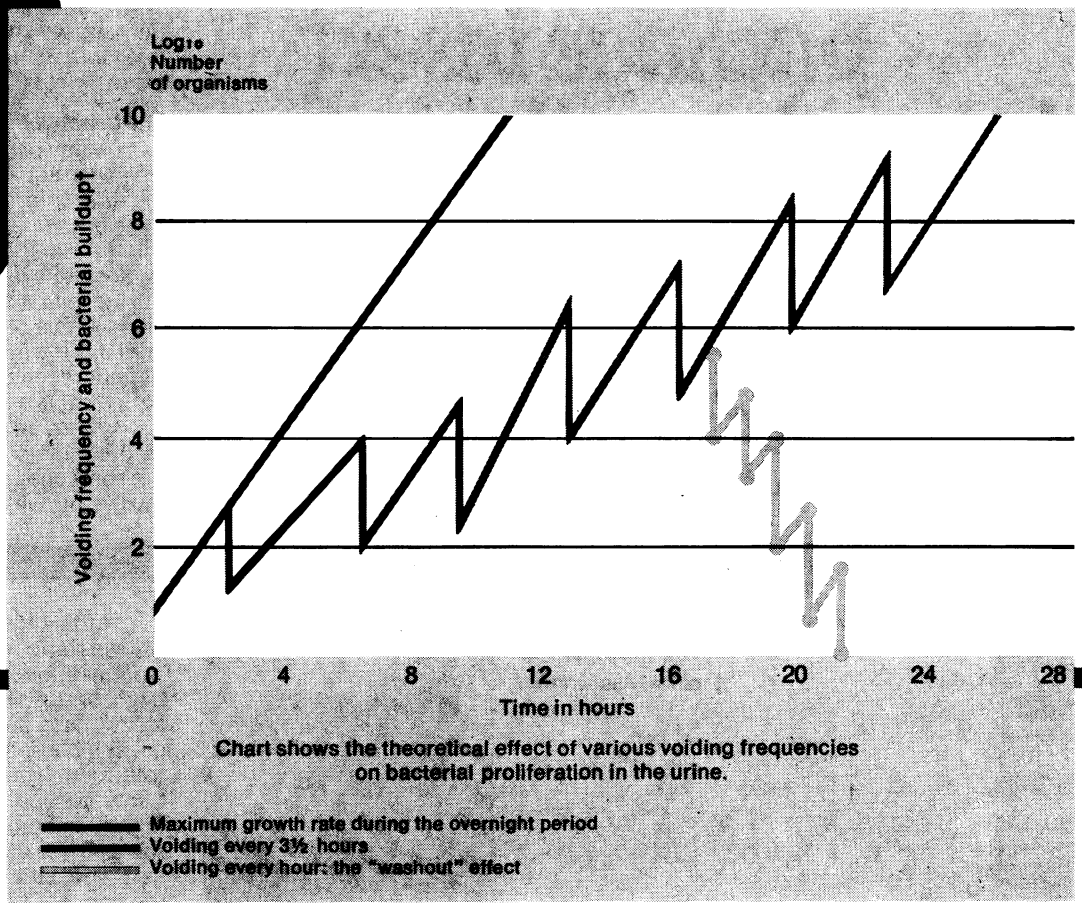
Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weigh initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE
Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Bacterial proliferation in the urine is a function of time and retention, as the chart below indicates. Because each 1-Gm dose provides up to 12 hours' antibacterial activity, Gantanol protects the patient during the hours of sleep, when urinary retention favors bacterial buildup in the bladder. Counts of susceptible *E. coli* are usually reduced from 10^5/ml to sterile urine within 48 hours.

your patient sleeps



†Adapted from O'Grady F, Cattell WR: *Brit J Urol 38*:156, 1966

For acute nonobstructed cystitis*

Gantanol® B.I.D.
sulfamethoxazole/Roche®

Basic therapy with convenience:
4 tablets (0.5 Gm each) STAT — then 2 tablets B.I.D. for 10-14 days

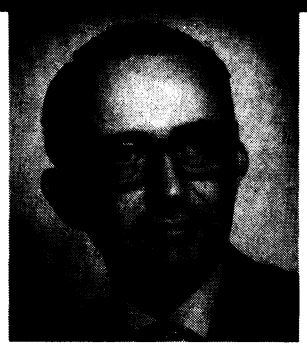
*due to susceptible organisms

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?

Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration

Dr. James H. Sammons
Executive Vice President
of the American
Medical Association



The idea of a so-called patient package insert has been around for a long time. Many physicians already use written instruction sheets to provide patients with information about the drugs they are taking. And some physicians give verbal instructions; but in too many instances these are what I call eye-glazing exercises. I have seen patients sit with glazed eyes listening to a rapid-fire lecture by a hurried physician who has 20 people out in his waiting room. These patients aren't given sufficient understanding and therefore do not follow instructions. So I think the idea of an official package insert for patients is a good one. Perhaps we should really think of this kind of information simply as an extension of drug labeling.

The benefits of patient involvement

Many physicians may not realize how frequently a patient obtains his drug information from Aunt Tillie or the next door neighbor. And this information is almost always bad or irrelevant to the case at hand. Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his prescription, is a bill.

As an educator I am impressed by the principle that the best way to get someone to do something is to involve him in the process. So the

I think there are advantages as well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medical terms to describe complications or possible sequelae of disease or treatment, you may frighten the patient—particularly since the more highly sophisticated patient is not the one who is going to read the insert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a package insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patient on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may possibly outweigh the potential good.

main purpose of drug information for the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

Diarrhea can hook anyone. When it does, physicians and patients both want prompt control of diarrheal symptoms. Lomotil will usually control diarrhea promptly.

This rapid action can halt the emergency aspect of diarrhea and is comforting and reassuring to the patient. Electrolyte and fluid losses can be corrected while the specific cause of the diarrhea is being determined. If an infective agent is the cause, appropriate specific therapy should be given along with Lomotil.

Lomotil is contraindicated in children less than 2 years old.

Lomotil®

TABLETS LIQUID

Each tablet and each 5 ml of liquid contain: diphenoxylate hydrochloride 2.5 mg. (Warning: May be habit forming.) atropine sulfate 0.025 mg.

holds the line.

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

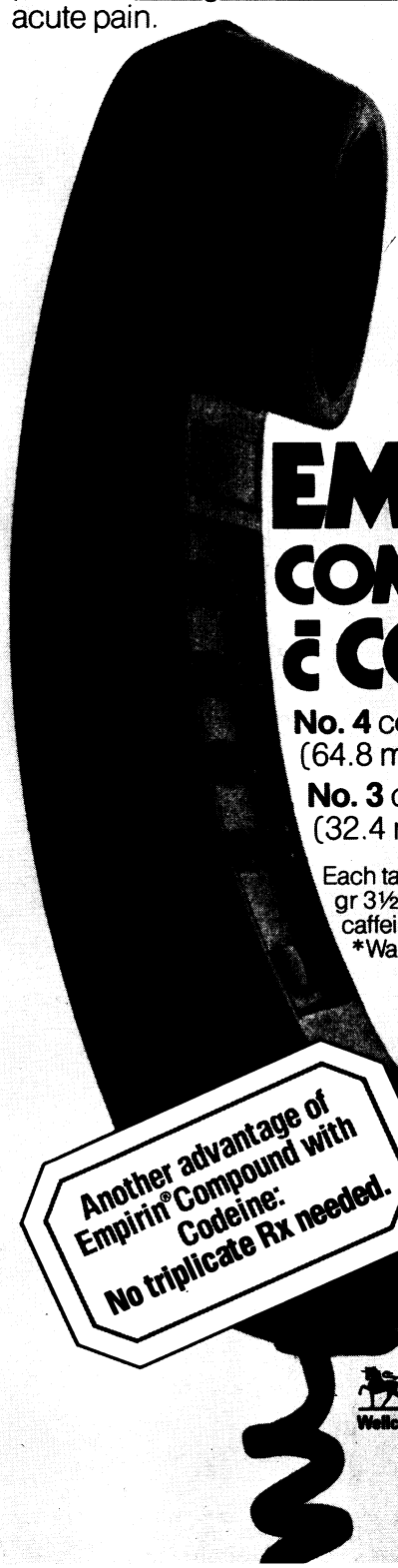
SEARLE **Searle & Co.**
San Juan, Puerto Rico 00936

Address medical inquiries to:
G. D. Searle & Co.
Medical Department, Box 5110,
Chicago, Illinois 60680

The Pain Phone

When a telephone prescription for pain relief is necessary or convenient, you can call in your order for Empirin Compound with Codeine in 45 of the 50 states† That includes No. 4, which provides a full grain of codeine for more intense, acute pain.

†The exceptions: Alaska, Arizona, Maine, Oregon, Rhode Island, and the District of Columbia.



EMPIRIN® COMPOUND ℂ CODEINE

No. 4 codeine phosphate* (64.8 mg) gr 1

No. 3 codeine phosphate* (32.4 mg) gr ½

Each tablet also contains aspirin gr 3½, phenacetin gr 2½, caffeine gr ½.
*Warning—may be habit-forming.

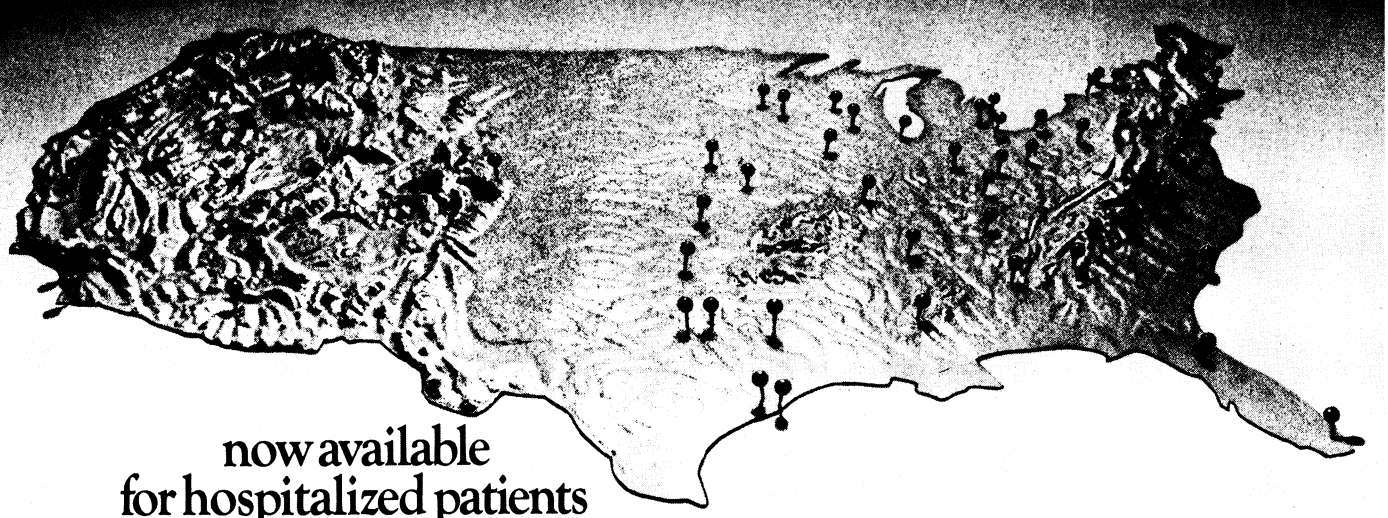
CIII

Another advantage of Empirin® Compound with Codeine: No triplicate Rx needed.

Wellcome **Burroughs Wellcome Co.**
Research Triangle Park
North Carolina 27709

An important new antibiotic for serious gram-negative infections*

wide investigational experience already in these areas



now available for hospitalized patients in your community

*Due to indicated susceptible organisms.

WARNINGS

Patients treated with Nebcin® (tobramycin sulfate, Lilly) should be under close clinical observation, because tobramycin and other aminoglycoside antibiotics have an inherent potential for causing ototoxicity and nephrotoxicity.

Both vestibular and auditory ototoxicity can occur. Eighth-nerve impairment may develop if patients have preexisting renal damage and if Nebcin is administered for longer periods or in higher doses than those recommended.

Tobramycin is potentially nephrotoxic. Renal and eighth-nerve function should be closely monitored in patients with known or suspected renal impairment and also in those whose renal function is initially normal but who develop signs of renal dysfunction during therapy. Such impairment may be characterized by cylindruria, oliguria, proteinuria, or evidence of nitrogen retention (increasing BUN, NPN, or creatinine). Evidence of impairment in renal, vestibular, or auditory function requires discontinuation of the drug or dosage adjustment.

Nebcin should be used with caution in premature and neonatal infants because of their renal immaturity and the resulting prolongation of serum half-life of the drug.

In the case of overdosage or toxic reactions, peritoneal dialysis or hemodialysis will help remove tobramycin from the blood.

Serum concentrations should be monitored when feasible, and prolonged concentrations above 12 mcg./ml. should be avoided. Urine should be examined for increased excretion of protein, cells, and casts.

Concurrent and sequential use of other neurotoxic and/or nephrotoxic antibiotics, particularly streptomycin, neomycin, kanamycin, gentamicin, cephaloridine, paromomycin, viomycin, polymyxin B, and colistin, should be avoided.

Nebcin should not be given concurrently with potent diuretics. Some diuretics themselves cause ototoxicity, and intravenously administered diuretics enhance aminoglycoside toxicity by altering antibiotic concentrations in serum and tissue.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Nebcin®
♦ I.M./I.V.

tobramycin sulfate

for serious infections including

septicemia

Bacterial cultures should be obtained prior to and during treatment. In patients in whom gram-negative septicemia or neonatal sepsis is suspected, including those in whom concurrent therapy with a penicillin or cephalosporin and an aminoglycoside may be indicated, treatment with Nebcin may be initiated before the results of susceptibility studies are obtained. The decision to continue therapy with Nebcin should be based on the results of susceptibility studies, the severity of the infection, and the important additional concepts discussed in the WARNINGS box in the prescribing information.

lower-respiratory-tract infections

Nebcin is indicated in bronchopneumonia, pneumonia, empyema, and bronchitis. Most patients treated in clinical trials had one or more of the following underlying respiratory tract conditions: asthma, cor pulmonale, cystic fibrosis, emphysema, bronchiectasis, lung cancer, empyema, and respiratory tract anomaly.

urinary tract infections

Nebcin is indicated in the treatment of serious complicated and recurrent urinary tract infections. Aminoglycosides, including Nebcin, are not indicated in uncomplicated initial episodes of urinary tract infections unless the causative organisms are not susceptible to antibiotics having less potential toxicity.

caused by susceptible strains of

Pseudomonas aeruginosa
Klebsiella-Enterobacter-Serratia group
Escherichia coli
Proteus sp. (indole-positive and indole-negative)
Providencia sp.
Citrobacter sp.
Group D streptococci
Staphylococci,* including *Staphylococcus aureus* (coagulase-positive and coagulase-negative)

* Nebcin may be considered in serious staphylococcal infections when penicillin or other potentially less toxic drugs are contraindicated and when bacterial susceptibility testing and clinical judgment indicate its use.

Please see following page for summary of prescribing information.

Nebcin® I.M./I.V.
tobramycin sulfate

Prescribing Information

WARNINGS

Patients treated with Nebcin should be under close clinical observation, because tobramycin and other aminoglycoside antibiotics have an inherent potential for causing ototoxicity and nephrotoxicity.

Both vestibular and auditory ototoxicity can occur. Eighth-nerve impairment may develop if patients have preexisting renal damage and if Nebcin is administered for longer periods or in higher doses than those recommended.

Tobramycin is potentially nephrotoxic. Renal and eighth-nerve function should be closely monitored in patients with known or suspected renal impairment and also in those whose renal function is initially normal but who develop signs of renal dysfunction during therapy. Such impairment may be characterized by cylindruria, oliguria, proteinuria, or evidence of nitrogen retention (increasing BUN, NPN, or creatinine). Evidence of impairment in renal, vestibular, or auditory function requires discontinuation of the drug or dosage adjustment.

Nebcin should be used with caution in premature and neonatal infants because of their renal immaturity and the resulting prolongation of serum half-life of the drug.

In the case of overdosage or toxic reactions, peritoneal dialysis or hemodialysis will help remove tobramycin from the blood.

Serum concentrations should be monitored when feasible, and prolonged concentrations above 12 mcg./ml. should be avoided. Urine should be examined for increased excretion of protein, cells, and casts.

Concurrent and sequential use of other neurotoxic and/or nephrotoxic antibiotics, particularly streptomycin, neomycin, kanamycin, gentamicin, cephaloridine, paromomycin, viomycin, polymyxin B, and colistin, should be avoided.

Nebcin should not be given concurrently with potent diuretics. Some diuretics themselves cause ototoxicity, and intravenously administered diuretics enhance aminoglycoside toxicity by altering antibiotic concentrations in serum and tissue.

Usage in Pregnancy—Safety of this product for use during pregnancy has not been established.

Description: Tobramycin sulfate, a water-soluble antibiotic of the aminoglycoside group, is derived from the actinomycete *Streptomyces tenebrarius*. Nebcin Injection is a clear and colorless sterile aqueous solution for parenteral administration. It is stable and requires no refrigeration.

Indications and Usage: Nebcin is indicated for the treatment of serious infections caused by susceptible strains of the following microorganisms: *Pseudomonas aeruginosa, Escherichia coli, Proteus* sp. (indole-positive and indole-negative), *Providencia, Klebsiella-Enterobacter-Serratia* group, *Citrobacter* sp., group D streptococci, and staphylococci, including *Staphylococcus aureus* (coagulase-positive and coagulase-negative).

Nebcin is indicated in the treatment of septicemia; central-nervous-system infections, including meningitis; neonatal sepsis; serious lower respiratory infections; gastrointestinal infections, including peritonitis; and serious skin, bone, and soft-tissue infections, including burns, caused by the susceptible organisms listed above. Clinical studies have shown Nebcin also to be effective in serious complicated and recurrent urinary tract infections due to these organisms. Aminoglycosides, including Nebcin, are not indicated in uncomplicated initial episodes of urinary tract infections unless the causative organisms are not susceptible to antibiotics having less potential toxicity. Nebcin may be considered in serious staphylococcal infections when penicillin or other potentially less toxic drugs are contraindicated and when bacterial susceptibility testing and clinical judgment indicate its use.

Bacterial cultures should be obtained prior to and during treatment to isolate and identify etiologic organisms and to test their susceptibility to tobramycin. If susceptibility tests show that the causative organisms are resistant to tobramycin, other appropriate therapy should be instituted. In patients in whom gram-negative septicemia, neonatal sepsis, or meningitis is suspected, including those in whom concurrent therapy with a penicillin or cephalosporin and an aminoglycoside may be indicated, treatment with Nebcin may be initiated before the results of susceptibility studies are obtained. The decision to continue therapy with Nebcin should be based on the results of susceptibility studies, the severity of the infection, and the important additional concepts discussed in the WARNINGS box above.

Contraindication: A history of hypersensitivity to tobramycin is a contraindication to its use.

Warnings: See WARNINGS box above.

Precautions: Specimens should be collected during therapy for examination, as recommended in the WARNINGS box.

Neuromuscular blockade and respiratory paralysis have been reported in cats receiving very high doses of tobramycin (40 mg./Kg.). The possibility that these phenomena may occur in man should be considered if tobramycin is administered to patients who are also receiving neuromuscular blocking agents, such as succinylcholine or tubocurarine.

Cross-allergenicity among aminoglycosides has been demonstrated.

If overgrowth of nonsusceptible organisms occurs, appropriate therapy should be initiated.

Adverse Reactions: *Nephrotoxicity*—Renal function changes, as shown by rising BUN, NPN, and serum creatinine and by oliguria, cylindruria, and increased proteinuria, have been reported, especially in patients with a history of renal impairment who are treated for longer periods or with higher doses than those recommended.

Neurotoxicity—Adverse effects on both the vestibular and auditory branches of the eighth nerve have been noted, especially in patients receiving high doses or prolonged therapy. Symptoms include dizziness, vertigo, tinnitus, roaring in the ears, and hearing loss.

NOTE: The risk of toxic reactions is low in patients with normal renal function who do not receive Nebcin in higher doses or for longer periods of time than those recommended.

Other reported adverse reactions possibly related to Nebcin include increased serum transaminase (SGOT, SGPT) and increased serum bilirubin; anemia, granulocytopenia, and thrombocytopenia; and fever, rash, itching, urticaria, nausea, vomiting, headache, and lethargy.

Suggested Dosage Guides—I.M./I.V.:

Usual dosage for adults, children, and older infants (normal renal function)—3 mg./Kg./day administered in three equal doses every eight hours. In life-threatening situations, the dosage may be increased up to 5 mg./Kg./day administered in three or four equal doses. This dosage should be reduced to 3 mg./Kg./day as soon as clinically indicated. (Refer to Table 1 for dosage schedule.)

Dosage for neonates up to one week of age (normal renal function)—Up to 4 mg./Kg./day may be given in two equal doses every twelve hours. The usual duration of treatment is seven to ten days.

Dosage guidelines for adult or pediatric patients with reduced renal function—After a loading dose of 1 mg./Kg., subsequent dosage must be adjusted either with reduced doses at eight-hour intervals or with normal doses at prolonged intervals. To determine the reduced dose at eight-hour intervals, see the convenient nomogram in the package literature.* To calculate normal dosage at prolonged intervals (if the creatinine clearance rate is not available and the patient's condition is stable), the following formula may be used:

$$1 \text{ mg./Kg. q. } (6 \times \text{serum creatinine}) \text{ h.}$$

Neither regimen should be used when dialysis is being performed.

I.V. Administration—The usual volume of diluent for adults is 50 to 100 ml. For children, the volume of diluent should be proportionately less than for adults. The diluted solution usually should be infused over a period of twenty to sixty minutes.

*An alternate rough guide for determining reduced dosage at eight-hour intervals (for patients whose steady-state serum creatinine values are known) is to divide the normally recommended dose by the patient's serum creatinine.

Table 1. Dosage Schedule Guide for Adults with Normal Renal Function (Dosage at Eight-Hour Intervals)

For Patient Weighing Kg.	Lb.	Usual Dose for Serious Infections 1 mg./Kg. q. 8 h. (Total, 3 mg./Kg./day)		Maximum Dose for Life-Threatening Infections **(Reduce as soon as possible)** 1.66 mg./Kg. q. 8 h. (Total, 5 mg./Kg./day)	
		mg./dose q. 8 h.	**ml./dose†**	**mg./dose q. 8 h.**	**ml./dose†**
120	264	120 mg.	3 ml.	200 mg.	5 ml.
115	253	115 mg.	2.9 ml.	191 mg.	4.75 ml.
110	242	110 mg.	2.75 ml.	183 mg.	4.5 ml.
105	231	105 mg.	2.6 ml.	175 mg.	4.4 ml.
100	220	100 mg.	2.5 ml.	166 mg.	4.2 ml.
95	209	95 mg.	2.4 ml.	158 mg.	4 ml.
90	198	90 mg.	2.25 ml.	150 mg.	3.75 ml.
85	187	85 mg.	2.1 ml.	141 mg.	3.5 ml.
80	176	80 mg.	2 ml.	133 mg.	3.3 ml.
75	165	75 mg.	1.9 ml.	125 mg.	3.1 ml.
70	154	70 mg.	1.75 ml.	116 mg.	2.9 ml.
65	143	65 mg.	1.6 ml.	108 mg.	2.7 ml.
60	132	60 mg.	1.5 ml.	100 mg.	2.5 ml.
55	121	55 mg.	1.4 ml.	91 mg.	2.25 ml.
50	110	50 mg.	1.25 ml.	83 mg.	2.1 ml.
45	99	45 mg.	1.1 ml.	75 mg.	1.9 ml.
40	88	40 mg.	1 ml.	66 mg.	1.6 ml.

†Applicable to all product forms except Nebcin, Pediatric, Injection (see How Supplied).

How Supplied: Ampoules Nebcin® (tobramycin sulfate, Lilly) Injection, 80 mg. (equivalent to tobramycin) per 2 ml., 2 ml., rubber-stoppered.

Ampoules Nebcin, Pediatric, Injection, 20 mg. (equivalent to tobramycin) per 2 ml., 2 ml., rubber-stoppered.

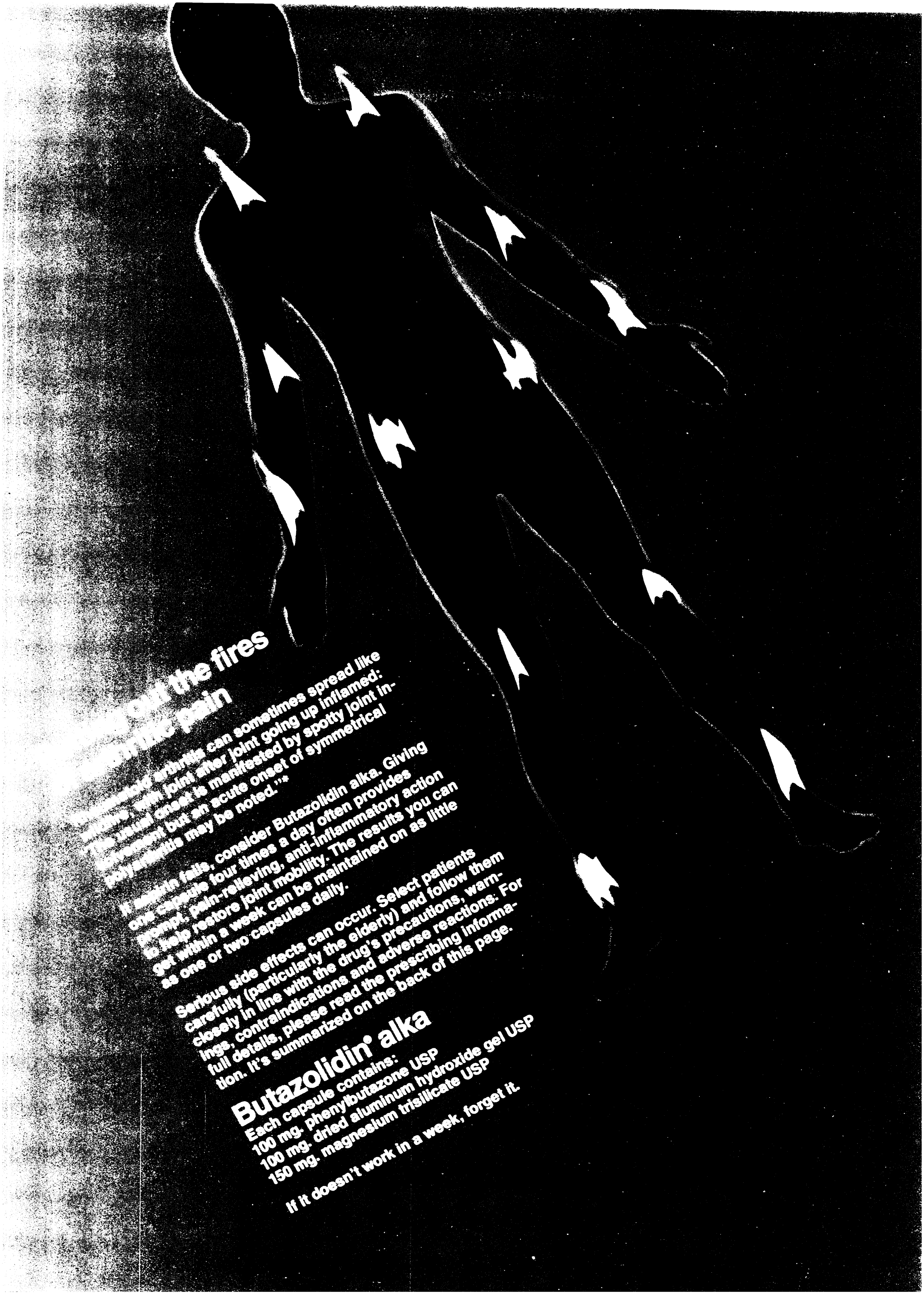
Hyporets® (disposable syringes, Lilly) Nebcin Injection, 60 mg. (equivalent to tobramycin) per 1.5 ml., 1.5 ml., and 80 mg. (equivalent to tobramycin) per 2 ml., 2 ml., in packages of 24.

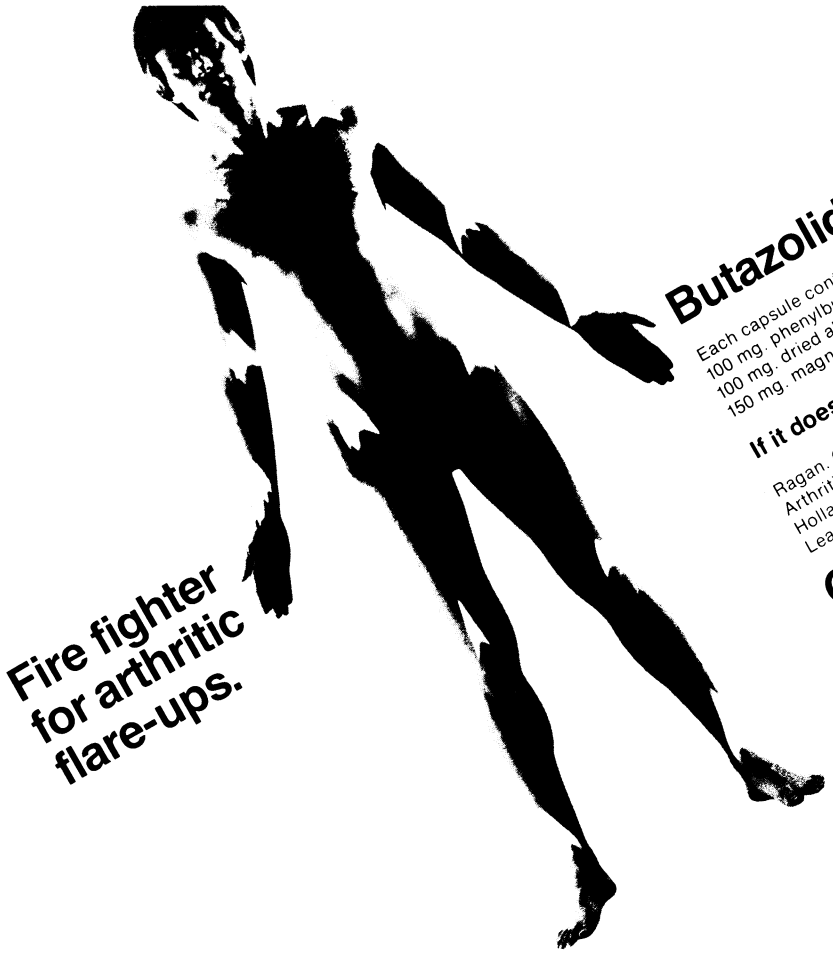
Each ml. also contains 5 mg. phenol as a preservative, 3.2 mg. sodium bisulfite, 0.1 mg. disodium edetate, and water for injection, q.s. Sulfuric acid and/or sodium hydroxide may have been added to adjust the pH. [063075]

Additional information available to the profession on request.

Eli Lilly and Company
Indianapolis, Indiana 46206

500779


out the fires
pain
arthritis can sometimes spread like
with joint after joint going up inflamed:
"The usual onset is manifested by spotty joint in-
volvement but an acute onset of symmetrical
polyarthritis may be noted."*
If aspirin fails, consider Butazolidin alka. Giving
one capsule four times a day often provides
prompt, pain-relieving, anti-inflammatory action
to help restore joint mobility. The results you can
get within a week can be maintained on as little
as one or two capsules daily.
Serious side effects can occur. Select patients
carefully (particularly the elderly) and follow them
closely in line with the drug's precautions, warn-
ings, contraindications and adverse reactions. For
full details, please read the prescribing informa-
tion. It's summarized on the back of this page.
Butazolidin® alka
Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP
If it doesn't work in a week, forget it.



Butazolidin® alka

Each capsule contains:
100 mg. phenylbutazone USP
100 mg. dried aluminum hydroxide gel USP
150 mg. magnesium trisilicate USP

If it doesn't work in a week, forget it.

Ragan, C.: The Clinical Picture of Rheumatoid Arthritis, in Arthritis, ed. 8, edited by J. L. Hollander and D. J. McCarty, Jr., Philadelphia, Lea & Febiger, 1972, chap. 21, p. 335.

Geigy

Fire fighter for arthritic flare-ups.

Important Note: This drug is not a simple analgesic. Do not administer casually. Carefully evaluate patients before starting treatment and keep them under close supervision. Obtain a detailed history, and complete physical and laboratory examination (complete hemogram, urinalysis, etc.) before prescribing and at frequent intervals thereafter. Carefully select patients, avoiding those responsive to routine measures, contraindicated patients or those who cannot be observed frequently. Warn patients not to exceed recommended dosage. Short-term relief of severe symptoms with the smallest possible dosage is the goal of therapy. Dosage should be taken with meals or a full glass of milk. Substitute alka capsules for tablets if dyspeptic symptoms occur. Patients should discontinue the drug and report immediately any sign of: fever, sore throat, oral lesions (symptoms of blood dyscrasia); dyspepsia, epigastric pain, symptoms of anemia, black or tarry stools or other evidence of intestinal ulceration or hemorrhage, skin reactions, significant weight gain or edema. A one-week trial period is adequate. Discontinue in the absence of a favorable response. Restrict treatment periods to one week in patients over sixty.

Indications: Rheumatoid arthritis, osteoarthritis, bursitis, acute gouty arthritis and rheumatoid spondylitis.

Contraindications: Children 14 years or less, senile patients, history or symptoms of G.I. inflammation or ulceration including severe, recurrent or persistent dyspepsia; history or presence of drug allergy; blood dyscrasias; renal, hepatic or cardiac dysfunction; hypertension; thyroid disease; systemic edema; stomatitis and salivary gland enlargement due to the drug; polymyalgia rheumatica and temporal arteritis; patients receiving other potent chemotherapeutic agents, or long-term anticoagulant therapy.

Warnings: Age, weight, dosage, duration of therapy, existance of concomitant diseases, and concurrent potent chemotherapy affect incidence of toxic reactions. Carefully instruct and observe the individual patient, especially the aging (forty years and over) who have increased susceptibility to the toxicity of the drug. Use lowest effective dosage. Weigh initially unpredictable benefits against potential risk of severe, even fatal, reactions. The disease condition itself is unaltered by the drug. Use with caution in first trimester of pregnancy and in nursing mothers. Drug may appear in cord blood and breast milk. Serious, even fatal, blood dyscrasias, including aplastic anemia, may occur suddenly despite regular hemograms, and may become manifest days or weeks after cessation of drug. Any significant change in total white count, relative decrease in granulocytes, appearance of immature forms, or fall in hematocrit should signal immediate cessation of therapy and complete hematologic investigation. Unexplained bleeding involving CNS, adrenals, and G.I. tract has occurred. The drug may potentiate action of insulin, sulfonylurea, and sulfonamide-type agents. Carefully observe patients taking these agents. Nontoxic and toxic goiters and myxedema have been reported (the drug reduces iodine uptake by the thyroid). Blurred vision can be a significant toxic symptom worthy of a complete ophthalmological examination. Swelling of ankles or face in patients under sixty may be prevented by reducing dosage. If edema occurs in patients over sixty, discontinue drug.

Precautions: The following should be accomplished at regular intervals: Careful detailed history for disease being treated and detection of earliest signs of adverse reactions; complete physical examination including check of patient's weight; complete weekly (especially for the aging) or an every two week blood check; pertinent laboratory studies. Caution patients about participating in activity requiring alertness and coordination, as driving a car, etc. Cases of leukemia have been reported in patients with a history of short- and long-term therapy. The majority of these patients were over forty. Remember that arthritic-type pains can be the presenting symptom of leukemia.

Adverse Reactions: This is a potent drug; its misuse can lead to serious results. Review detailed information before beginning therapy. Ulcerative esophagitis, acute and reactivated gastric and duodenal ulcer with perforation and hemorrhage, ulceration and perforation of large bowel, occult G.I. bleeding with anemia, gastritis, epigastric pain, hematemesis, dyspepsia, nausea, vomiting and diarrhea, abdominal distention, agranulocytosis, aplastic anemia, hemolytic anemia, anemia due to blood loss including occult G.I. bleeding, thrombocytopenia, pancytopenia, leukemia, leukopenia, bone marrow depression, sodium and chloride retention, water retention and edema, plasma dilution, respiratory alkalosis, metabolic acidosis, fatal and nonfatal hepatitis (cholestasis may or may not be prominent), petechiae, purpura without thrombocytopenia, toxic pruritus, erythema nodosum, erythema multiforme, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), exfoliative dermatitis, serum sickness, hypersensitivity angiitis (polyarteritis), anaphylactic shock, urticaria, arthralgia, fever, rashes (all allergic reactions require prompt and permanent withdrawal of the drug), proteinuria, hematuria, oliguria, anuria, renal failure with azotemia, glomerulonephritis, acute tubular necrosis, nephrotic syndrome, bilateral renal cortical necrosis, renal stones, ureteral obstruction with uric acid crystals due to uricosuric action of drug, impaired renal function, cardiac decompensation, hypertension, pericarditis, diffuse interstitial myocarditis with muscle necrosis, perivascular granulomata, aggravation of temporal arteritis in patients with polymyalgia rheumatica, optic neuritis, blurred vision, retinal hemorrhage, toxic amblyopia, retinal detachment, hearing loss, hyperglycemia, thyroid hyperplasia, toxic goiter, association of hyperthyroidism and hypothyroidism (causal relationship not established), agitation, confusional states, lethargy; CNS reactions associated with overdosage, including convulsions, euphoria, psychosis, depression, headaches, hallucinations, giddiness, vertigo, coma, hyperventilation, insomnia; ulcerative stomatitis, salivary gland enlargement.

(B)98-146-070-J (10/71)

For complete details, including dosage, please see full prescribing information.

GEIGY Pharmaceuticals
Division of CIBA-GEIGY Corporation
Ardsley, New York 10502

BU 10259

MEDICAL ANCILLARY SERVICES, INC.

- Since 1961, we have never met an administrative health care problem we didn't solve.
- We will not only diagnose your problem—we will provide the treatment, including the continuing care, and we will "guarantee the cure"!

- Whatever the symptoms—wherever your location—we would like to share our problem solving success with you

FOR EXAMPLE

- WE HAVE DIAGNOSED, TREATED AND CURED **EMERGENCY DEPARTMENT PROBLEMS** THROUGHOUT THE UNITED STATES
- OUR CLIENTS, DOCTORS AND HOSPITALS, HAVE NEVER HAD A RELAPSE

Call us at **(415) 321-2202** or Toll Free **1-(800) 521-5642**

OR

DETACH AND MAIL

MEDICAL ANCILLARY SERVICES, Inc.
Suite 1110, 701 Welch Road
Palo Alto, California 94304

Name _____ Phone _____

Address _____ Date _____

City _____ State _____ Zip _____

CALIFORNIA
MEDICAL ASSOCIATION

105th Annual Session
AND
Western Scientific Assembly

February 6-11, 1976 • Hyatt Regency and Sheraton-Palace Hotels, San Francisco

PLAN TO ATTEND

PROGRAMS

- Cancer of the GI tract: the gut issues
- Current misconceptions about anxiety
- Sexuality: an essential dimension in patient care
- Neurological problems of the school-age child
- Early intervention in neuromuscular disorders
- Rheumatoid disease in childhood
- Myelomeningocele
- Everything you always wanted to know about a thyroid nodule but were afraid to ask
- Electroconvulsive therapy controversy
- Thyroid cancer
- The cornea
- Repair of eyelids after trauma
- Common problems in allergy and dermatology
- Special problems in asthma
- Athletic injuries
- Environmental and occupational impact on the lung
- Sexual desire and ability with drug use
- New trends in Dx of pancreatic and biliary lesions
- Urologic plastic surgery
- Skin problems of women
- Adolescent medicine and sexuality
- Death and dying—How to avoid a "cop out"

"MEET THE PROFESSOR" LUNCHEONS EACH DAY

WORKSHOPS

- Ear, nose and throat problems of children
- Plastic surgery suturing techniques

AFFILIATED MEETINGS

- American Cancer Society, California Division
- American College of Physicians, Northern California Region
- California Association on Ophthalmology
- California Society for the Treatment of Alcoholism and Other Drug Dependence
- California Society of Allergy and Clinical Immunology
- California Tumor Tissue Registry

OVER ONE HUNDRED SCIENTIFIC AND TECHNICAL EXHIBITS

46th Annual Convention—Woman's Auxiliary to California Medical Association

CALIFORNIA MEDICAL ASSOCIATION HOUSE OF DELEGATES

For Hotel Reservations, see Advertising Page 33

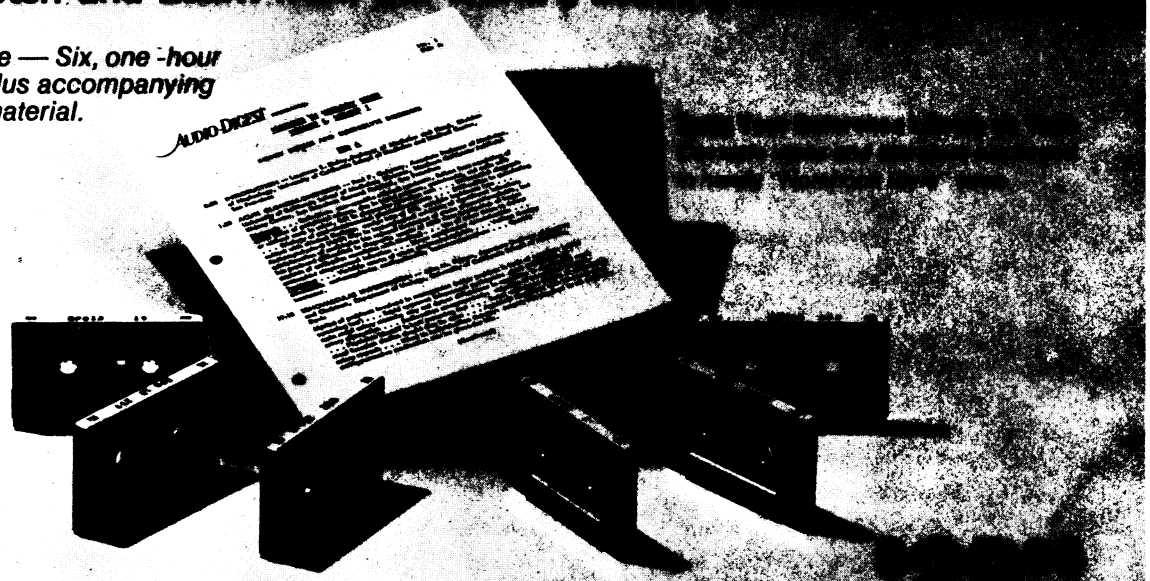
Announcing **10** **Special Postgraduate Educational Courses**

from AUDIO-DIGEST

23 YEARS OF SERVICE TO DOCTORS

Now Listen and Learn

Each Course — Six, one-hour cassettes plus accompanying reference material.



- **Cardiology Update**
- **Respiratory Therapy**
- **Gastroenterology Short Course**
- **Cancer Therapy**
- **Problems in Urology**
- **Allergy Short Course**

Just released . . .

- **Emergency Medicine**
- **Neurology Short Courses**
- **Pulmonary Problems**
- **Hypertension Short Course**

ORDER COURSES BELOW OR SEND FOR YOUR FREE CATALOG OF SPECIAL SERIES

ORDER CERTIFICATE — Please enter my order for the special six-hour courses listed below. I've enclosed $29.95 for each course. In Canada, please add $2.06 for postage (each course) — other countries add $2.61 postage for each course (payable in U.S. funds.)

- ☐ Special Series 1 — ***Cardiology Update***
- ☐ Special Series 2 — ***Respiratory Therapy***
- ☐ Special Series 3 — ***Gastroenterology Short Course***
- ☐ Special Series 4 — ***Cancer Therapy***
- ☐ Special Series 5 — ***Problems in Urology***
- ☐ Special Series 6 — ***Allergy Short Course***
- ☐ Special Series 7 — ***Emergency Medicine***
- ☐ Special Series 8 — ***Neurology Short Courses***
- ☐ Special Series 9 — ***Pulmonary Problems***
- ☐ Special Series 10 — ***Hypertension Short Course***

Prices Subject to Change Without Notice. 6661

☐ Please send me my free copy of the Catalog of Special Series

Name _____
(Please print or stamp)

Address _____

City _____

State or Province _____ Zip Code _____

W-1

Audio-Digest Foundation
A non-profit subsidiary of the California Medical Association
1250 S. Glendale Avenue, Glendale, California 91205

to help treat what you often find: obvious moderate to severe anxiety with a less obvious underlying depression

TRIAVIL®

containing perphenazine and amitriptyline HCl

a tranquilizer–antidepressant

"...and she'd jump every time the phone rang."

"All right, I agree, she was obviously very anxious...you said she hadn't been sleeping..."

"She felt *tired enough* to sleep... not relaxed enough...food, too... she's too nervous to eat...says she *can't* relax...afraid there's something very wrong with her."

"...that's a good place to start! Did you find anything wrong with her?"

Treatment with TRIAVIL—a balanced view.

Tablets TRIAVIL are available in four different combinations affording flexibility and individualized dosage adjustment. Close supervision of patients is essential until satisfactory remission has taken place. Since suicide is a possibility in any depressive illness, patients should not have easy access to large quantities of the drug. The drug may impair alertness and potentiate the response to alcohol. It should not be used during the acute recovery phase following myocardial infarction or given to patients who have received an MAOI within two weeks. TRIAVIL should be used with caution in glaucoma and in patients prone to urinary retention. It is contraindicated in CNS depression and in the presence of evidence of bone marrow depression.

MSD MERCK SHARP DOHME

For a brief summary of prescribing information, please turn to the following page.

'Not a thing... negative... nothing organically wrong. Still has a fair list of somatic complaints. I've tried to reassure her... to let her talk... to help her sort things out. She's been in to see me a number of times."

"...what about medication?"

"Just what I was coming to... I've had her on tranquilizers. And *that's* what puzzles me. I'm not getting the response I hoped for. She's no better... perhaps a little worse. It's sad to see."

"...I think *'sad'* may be what you're not seeing! You know, this sounds like another case where the *anxiety* is so clear and pervasive we tend to overlook the depressive part of the picture. I'm not sure that we shouldn't almost always think of anxiety *with* depression... not anxiety alone. Take another look at your records... talk to her some more. If you decide she's depressed, I think you might want to consider TRIAVIL.... It can help relieve her entire symptom complex... control the anxiety... while at the same time treat the depression."

TRIAVIL®

to help treat what you often find: obvious moderate to severe anxiety with a less obvious underlying depression

containing perphenazine and amitriptyline HCl

an antidepressant tranquilizer

Available:

TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl

TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl

TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl

INITIAL THERAPY FOR MANY PATIENTS
TRIAVIL® 2-25 (or TRIAVIL® 4-25) t.i.d. or q.i.d.

FOR FLEXIBILITY IN ADJUSTING MAINTENANCE THERAPY
TRIAVIL® 2-10 (or TRIAVIL® 4-10)

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Do not give concomitantly with MAOI drugs because hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. Allow minimum of 14 days between therapies, then initiate therapy with TRIAVIL cautiously, with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given with guanethidine or similarly acting compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, particularly in high doses, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Caution patients performing hazardous tasks, such as operating machinery or driving motor vehicles, that drug may impair mental and/or physical abilities. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Side effects may be any of those reported with phenothiazine drugs: extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw (e.g., protrusion of tongue, puffing of cheeks, puckering of mouth, chewing movements). Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. It has been suggested that fine vermicular movements of the tongue may be an early sign of the syndrome, and that the full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude, muscle weakness, mild insomnia. Other adverse reactions reported with various phenothiazine compounds include blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); grand mal convulsions; cerebral edema; polyphagia; photophobia; skin pigmentation; and failure of ejaculation.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness; weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; jaundice; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1—3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

For more detailed information, consult your MSD Representative or see full Prescribing Information.
Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP & DOHME

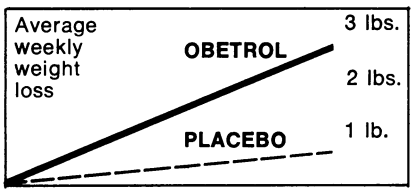
EFFECTIVE APPETITE DEPRESSANT with predictable pharmacological action

OBETROL® C II

Single entity amphetamine product. Each OBETROL-10 (10 mg. tablet) contains: dextroamphetamine saccharate 2.5 mg., amphetamine aspartate 2.5 mg., dextroamphetamine sulfate 2.5 mg., amphetamine sulfate 2.5 mg. OBETROL-20 (20 mg. tablets) contain twice this potency.

Average weight loss of 2.15 lbs per week compared in clinical studies against a placebo.

CONTROLLED STUDY —
72 CASES 4 WEEKS' RESULTS



Obetrol eases the discomfort of adherence to a restricted diet in individuals who are well motivated to reduce their food intake.

Clinical studies disclose amphetamines to be the most dependable drug in a weight-reduction regimen compared to other anorexigenic agents.

Amphetamines have a significant potential for abuse. In view of their limited short-term anorectic effect and rapid development of tolerance, they should be used with extreme caution and only for limited periods of time in weight reduction programs.

Actions: Amphetamines are sympathomimetic amines with CNS stimulant activity. Peripheral actions include elevation of systolic and diastolic blood pressures and weak bronchodilator and respiratory stimulant action. The anorectic effect diminishes after a few weeks.

Indications: Exogenous obesity, as a short term (a few weeks) adjunct in a regimen of weight reduction based on caloric restriction. For patients in whom obesity is refractory to other measures.

Contraindications: Advanced arteriosclerosis, symptomatic cardiovascular disease, moderate to severe hypertension, hyperthyroidism, known hypersensitivity or idiosyncracy to the sympathomimetic amines. • Agitated states. • Patients with a history of drug abuse. • During or within 14 days following the administration of monoamine oxidase inhibitors, hypertensive crises may result.

Warnings: Tolerance to the anorectic effect usually develops within a few weeks. When this occurs, the recommended dose should not be exceeded in an attempt to increase the effect, rather, the drug should be discontinued. Amphetamines may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Precautions: Caution is to be exercised in prescribing amphetamines for patients with even mild hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of amphetamines and the concomitant dietary regimen. Amphetamines may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage.

Adverse Reactions: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure. Central nervous system: Overstimulation, restlessness, dizziness, insomnia, euphoria, dysphoria, tremor, headache; rarely, psychotic episodes at recommended doses. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, diarrhea, other gastrointestinal disturbances. Anorexia and weight loss may occur as undesirable effects when amphetamines are used for other than the anorectic effect. *Allergic:* Urticaria. *Endocrine:* Impotence, changes in libido.

Dosage and Administration: Regardless of indication, amphetamines should be administered at the lowest effective dosage and dosage should be individually adjusted. Late evening medication should be avoided because of the resulting insomnia.

1. Narcolepsy: Usual dose 5 to 60 milligrams per day in divided doses.
2. Minimal brain dysfunction:
   a. Not recommended for children under 3 years of age.
   b. Children from 3 to 5 years of age: 2.5 milligrams daily, raised in increments of 2.5 milligrams at weekly intervals until optimal response is obtained.
   c. Children 6 years of age and older, 5 milligrams, once or twice daily, increased in increments of 5 milligrams at weekly intervals. Only in rare cases will it be necessary to exceed a total of 40 milligrams per day.
3. Obesity: Usual adult dose 5 to 30 milligrams per day in divided doses.

Overdosage: Manifestations of acute overdosage with amphetamines include restlessness, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension, and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management of acute amphetamine intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

Availability: Supplied in bottles of 100; 500 and 1,000 tablets.

CAUTION: FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION.

January 1973

Comprehensive informational brochure available upon written request. Prescribe Obetrol for appetite control.

OBETROL Pharmaceuticals Division/Rexar Pharmacal Corp.
Valley Stream, New York 11582

IN GONORRHEA

INJECTION

Wycillin®

(STERILE PROCAINE PENICILLIN G SUSPENSION) WYETH

In **Gonorrhea,** the drug regimen of choice is aqueous procaine penicillin G. In uncomplicated cases, administration of 4.8 million units together with 1 gram oral probenecid, given at least 30 minutes prior to injection, is recommended.

Indications: In treatment of moderately severe infections due to penicillin G-sensitive microorganisms sensitive to the low and persistent serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

NOTE: When high sustained serum levels are required use aqueous penicillin G, IM or IV.

The following infection will usually respond to adequate dosages of intramuscular procaine penicillin G.—*N. gonorrhoeae:* acute and chronic (without bacteremia).

For deep intramuscular injection only.

Contraindication: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin therapy.

Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen and intravenous corticosteroids should also be administered as indicated.

Although anaphylaxis is more frequent following parenteral therapy it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with a history of sensitivity to multiple allergens.

There have been well documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before therapy with a penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, the drug should be discontinued and the patient treated with the usual agents e.g., pressor amines, antihistamines and corticosteroids.

Mental disturbances, including anxiety, confusion, agitation, depression, and hallucinations, have been reported in individuals following single-dose schedules for gonorrhea. Reactions have been transient, lasting from 15-30 minutes.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injections may produce neurovascular damage.

A small percentage of patients are sensitive to procaine. If there is a history of sensitivity, make the usual test: Inject intradermally 0.1 cc. of a 1 to 2 percent procaine solution. Development of an erythema, wheal, flare or eruption indicates procaine sensitivity. Sensitivity should be treated by the usual methods, including barbiturates, and procaine penicillin preparations should not be used. Antihistaminics appear beneficial in treatment of procaine reaction.

The use of antibiotics may result in overgrowth of nonsusceptible organisms. Constant observation of the patient is essential. If new infections due to bacteria or fungi appear during therapy, discontinue penicillin and take appropriate measures.

If allergic reaction occurs, withdraw penicillin unless, in the opinion of the physician, the condition being treated is life threatening and amenable only to penicillin therapy.

When treating gonococcal infections with suspected primary or secondary syphilis, perform proper diagnostic procedures, including darkfield examinations. In all cases in which concomitant syphilis is suspected, perform monthly serological tests for at least four months.

Adverse Reactions: (Penicillin has significant index of sensitization) skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported. (See "Warnings.")

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Dosage and Administration : Administer only by *deep intramuscular injection,* in upper outer quadrant of buttock. In infants and small children, midlateral aspect of thigh may be preferable. When doses are repeated, vary injection site. Before injection, aspirate to be sure needle bevel is not in blood vessel. If blood appears, remove needle and inject in another site.

Although some isolates of *Neisseria gonorrhoeae* have decreased susceptibility to penicillin, this resistance is relative, not absolute, and penicillin in large doses remains the drug of choice. Physicians are cautioned not to use less than recommended doses.

Gonorrheal infections (uncomplicated)—Men or Women: 4.8 million units intramuscularly divided into at least two doses and injected at different sites at one visit, together with 1 gram of oral probenecid, preferably given at least 30 minutes prior to injection.

NOTE: Treatment of severe complications of gonorrhea should be individualized using large amounts of short-acting penicillin. Gonorrheal endocarditis should be treated intensively with aqueous penicillin G. Prophylactic or epidemiologic treatment for gonorrhea (male and female) is accomplished with same treatment schedules as for uncomplicated gonorrhea.

Retreatment: The National Center for Disease Control, Venereal Disease Branch, U.S. Dept. H.E.W. recommends:

Test cure procedures at approximately 7-14 days after therapy. In the male, a gram-stained smear is adequate if positive; otherwise, a culture specimen should be obtained from the anterior urethra. In the female, culture specimens should be obtained from both the endocervical and anal canal sites.

Retreatment in males is indicated if urethral discharge persists 3 or more days following initial therapy and smear or culture remains positive. Follow-up treatment consists of 4.8 million units aqueous procaine penicillin G, I.M. divided in 2 injection sites at single visit.

In uncomplicated gonorrhea in the female, retreatment is indicated if follow-up cervical or rectal cultures remain positive for *N. gonorrhoeae.* Follow-up treatment consists of 4.8 million units aqueous procaine penicillin G daily on 2 successive days.

Syphilis: all gonorrhea patients should have a serologic test for syphilis at the time of diagnosis. Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Composition: Each disposable syringe 2,400,000 units (4-cc. size) contains procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer, and as w/v approximately 0.5% lecithin, 0.5% carboxymethylcellulose, 0.5% povidone, 0.1% methylparaben, and 0.01% propylparaben. The multiple-dose 10-cc. vial contains per cc. 300,000 units procaine penicillin G in a stabilized aqueous suspension with sodium citrate buffer and approximately 7 mg. lecithin, 2 mg. carboxymethylcellulose, 3 mg. povidone, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Five are graduating with honors. How many with VD?

On the average, you can figure the incidence of VD among teenagers at about 900 per 100,000 population* And growing.

Among those in the 20-24 age-group, the incidence is even higher. And it, too, is growing.

In the long run, a populace educated to the risks and prevention of VD is probably the best answer to the problem. Meanwhile, though, adequate doses of the recommended types of penicillin remain a formidable weapon.

IN SYPHILIS
INJECTION
Bicillin® L-A
(STERILE BENZATHINE PENICILLIN G SUSPENSION) WYETH

Syphilis is preferably treated with benzathine penicillin G, which is also the drug of choice for prophylaxis after exposure. Administration of 2.4 million units (1.2 million in each buttock) usually cures most cases of primary, secondary and latent syphilis with negative spinal fluid.

Indications: In treatment of infections due to penicillin G-sensitive microorganisms that are susceptible to the low and very prolonged serum levels common to this particular dosage form. Therapy should be guided by bacteriological studies (including sensitivity tests) and by clinical response.

The following infections will usually respond to adequate dosage of intramuscular benzathine penicillin G.—Venereal infections: Syphilis, yaws, bejel and pinta.

For deep intramuscular injection only.

Contraindication: Previous hypersensitivity reaction to any penicillin.

Warnings: Serious and occasionally fatal hypersensitivity (anaphylactoid) reactions have been reported. Anaphylaxis is more frequent following parenteral therapy but has occurred with oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens.

Severe hypersensitivity reactions with cephalosporins have been well documented in patients with history of penicillin hypersensitivity. Before penicillin therapy, carefully inquire into previous hypersensitivity to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and treat with usual agents, e.g., pressor amines, antihistamines and corticosteroids.

Precautions: Use cautiously in individuals with histories of significant allergies and/or asthma.

Carefully avoid intravenous or intraarterial use, or injection into or near major peripheral nerves or blood vessels, since such injection may produce neurovascular damage.

In streptococcal infections, therapy must be sufficient to eliminate the organism; otherwise the sequelae of streptococcal disease may occur. Take cultures following completion of treatment to determine whether streptococci have been eradicated.

Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms including fungi. Take appropriate measures should superinfection occur.

Adverse Reactions: Hypersensitivity reactions reported are skin eruptions (maculopapular to exfoliative dermatitis), urticaria and other serum sickness-like reactions, laryngeal edema and anaphylaxis. Fever and eosinophilia may frequently be only reaction observed. Hemolytic anemia, leucopenia, thrombocytopenia, neuropathy and nephropathy are infrequent and usually associated with high doses of parenteral penicillin.

As with other antisyphilitics, Jarisch-Herxheimer reaction has been reported.

Dosage and Administration: Venereal infections—

Syphilis—Primary, secondary and latent—2.4 million units (1 dose).

Late (tertiary and neurosyphilis)—2.4 million units at 7 day intervals for three doses.

Congenital—under 2 years of age, 50,000 units/Kg. body weight; ages 2-12 years, adjust dosage based on adult dosage schedule.

(Shake multiple-dose vial vigorously before withdrawing the desired dose.) Administer by **deep intramuscular injection** in the upper outer quadrant of the buttock. In infants and small children, the midlateral aspect of the thigh may be preferable. When doses are repeated, vary the injection site. Before injecting the dose, aspirate to be sure needle bevel is not in a blood vessel. If blood appears, remove the needle and inject in another site.

Composition: Units benzathine penicillin G (as active ingredient): 2,400,000 units in 4-cc. single dose disposable syringe. Each disposable syringe also contains in aqueous suspension with sodium citrate buffer, as w/v approximately 0.5% lecithin, 0.6% carboxymethylcellulose, 0.6% povidone, 0.1% methylparaben, and 0.01% propylparaben. 300,000 units per cc.—10-cc. multi-dose vial. Each cc. also contains sodium citrate buffer, approximately 6 mg. lecithin, 3 mg. povidone, 1 mg. carboxymethylcellulose, 0.5 mg. sorbitan monopalmitate, 0.5 mg. polyoxyethylene sorbitan monopalmitate, 1.2 mg. methylparaben, and 0.14 mg. propylparaben.

Wyeth Laboratories
Philadelphia, Pa. 19101
TM

*U.S. Dept. of Health, Education, and Welfare. VD Fact Sheet 1978. Publication No. (HSM) 78-8196.

Famous Fighters

NEOSPORIN® Ointment
(polymyxin B-bacitracin-neomycin)
is a famous fighter, too.

Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

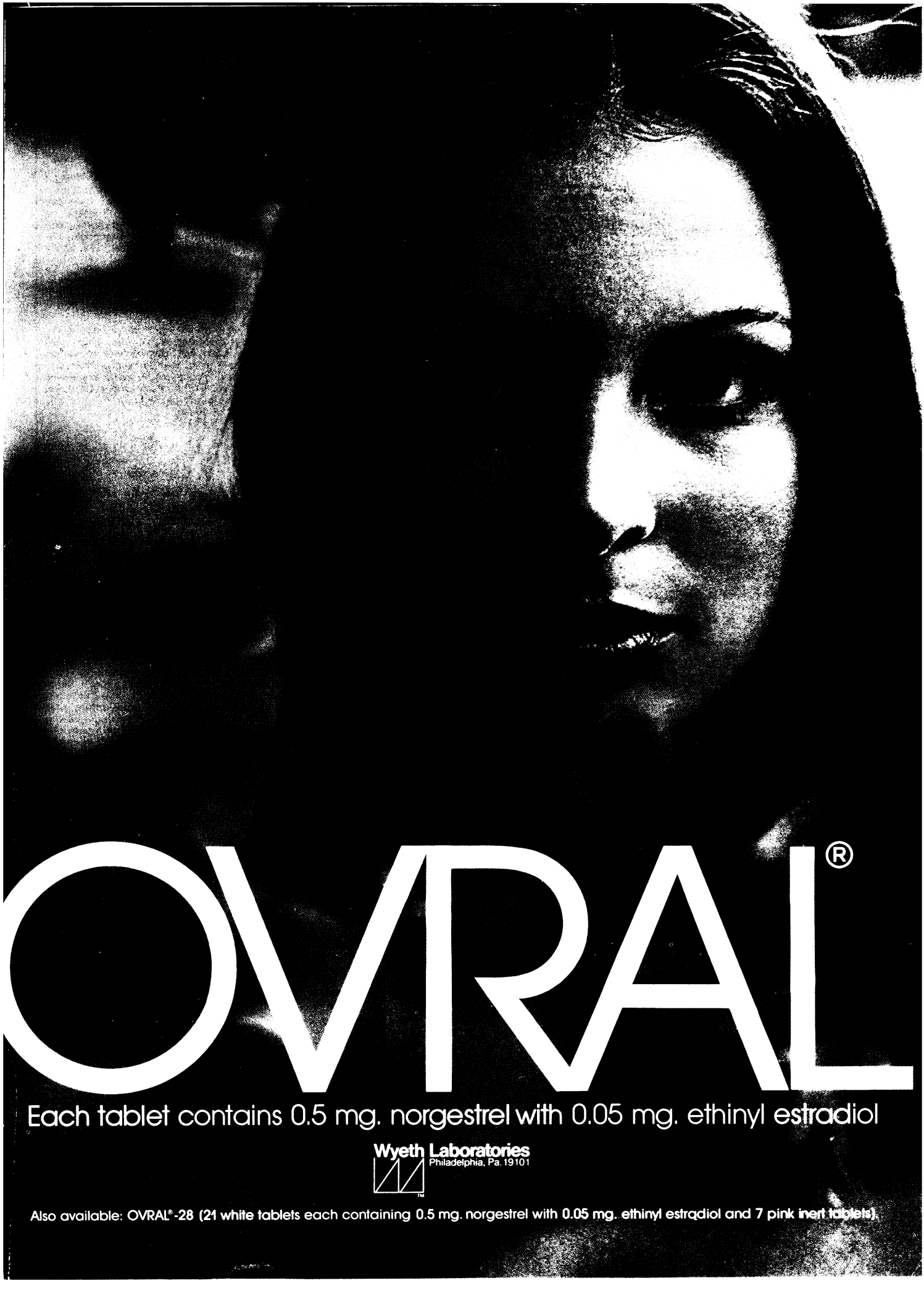
INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709


OVRAL®
Each tablet contains 0.5 mg. norgestrel with 0.05 mg. ethinyl estradiol
Wyeth Laboratories
Philadelphia, Pa. 19101
Also available: OVRAL®-28 (21 white tablets each containing 0.5 mg. norgestrel with 0.05 mg. ethinyl estradiol and 7 pink inert tablets).

Classified Advertisements

The rate for each insertion is **$2.50 per line** (average six words per line) **with five line minimum.**

Box number charge: $1.50 each month.

Classified display rates $25.00 per inch.

Copy for classified advertisements should be received not later than **the fifth of the month preceding issue.** • Classified advertisers using Box Numbers forbid the disclosure of their identity. Your inquiries in writing will be forwarded to Box Number advertisers. The right is reserved to reject or modify all classified advertising copy in conformity with the rules of the Advertising Committee.

CLASSIFIED ADVERTISEMENTS ARE PAYABLE IN ADVANCE

PHYSICIANS WANTED

PRACTICE IN BEAUTIFUL SANTA BARBARA. Excellent opportunity for experienced G.P., solo family practice established thirteen years, bilingual (English and Spanish), grossing $120,000 available without cost to qualified physician. Fully equipped office for lease or sale, office staff available, will introduce, available now. Leaving for service Jan. 1976. Night and week coverage shared by eight other physicians. Excellent hospital facilities. Contact D. John Barker, MD, 10 W. Micheltorena St., Santa Barbara, CA 93101—Phone (805) 963-3454.

CARDIOLOGIST-INTERNIST to become part of an active Southern California Cardiology Group. Practice includes care of ambulatory and hospitalized patients, ICU-CCU, non-invasive studies, post-operative care. Catheterization experience desirable but not obligatory. Write or call, Anaheim Cardiology Medical Group, 1741 W. Romneya Dr., Anaheim, CA 92801, (714) 776-5920.

STEINBECK COUNTRY: PROGRESSIVE rural group practice located in the Salinas Valley has an immediate need for a RADIOLOGIST and a FAMILY PRACTITIONER. The group, consisting of 10 full-time physicians and 11 consultants representing a wide spectrum of specialties provides medical services on a fee-for-service basis to a population area of approximately 22,000. Included in this area of responsibility is a 40-bed acute care community supported hospital with 6 skilled nursing beds, and a 25-bed intermediate care facility. Top fringe benefits, including competitive starting salary with early affiliation. Please call or send C.V. to: Duane F. Hyde, MD; Southern Monterey County Medical Group (A Professional Corporation), 210 Canal St., King City, CA 93930. (408) 385-5471.

GENERAL SURGEON, CERTIFIED. Large multispecialty group with active office and hospital practice. Salary $50,000 to $60,000 range, malpractice, retirement and all other benefits paid, teaching opportunities. Excellent schools, cultural activities and outdoor sports. Full vitae and references invited. Box 80100, Saint Paul, Minnesota 55108.

Excellent opportunity to practice in Ontario, California, a town of 80,000 located midway between Los Angeles and Palm Springs. Hospital draws from an area of over 250,000.

Seeking a **Chief of Pediatrics** (there is no other pediatrician in town), a **Chief of Urology,** a **Chief of Internal Medicine,** and a **Chief of Family Practice.** Free office rent—for six months. Guaranteed $50,000 gross first year. An opportunity to practice a high standard of medicine devoid of any economic stress or competition.

Phone "collect" at **(714) 984-2201**
Chairman, Search Committee

PHYSICIANS WANTED

WANTED—Internist to join three-man Northern California Internal Medicine Group in acute consultative, hospital and office practice. Salary leading to full partnership in two years. Subspecialty training encouraged. Reply with curriculum vitae to Box 9432. The Western Journal of Medicine, 731 Market St., San Francisco, CA 94103.

COLORADO PSYCHIATRISTS, adult and child, FT for growing HMO beginning 1976. Emphasis on eclec., brief and group therapy. Sal. nego. No private practice allowed. Good fringe benefits. CONTACT: W. L. Reimers, MD, Colorado Permanente Med. Grp., 2045 Franklin St., Denver, CO 80205. Phone (303) 892-7771, ext. 350.

POSITIONS AVAILABLE for Board Certified/Eligible. General Internists for addition to multispecialty group beginning November, 1975. Position open also for Internist/Gastroenterologist in January, 1976. Contact: Colorado Permanente Medical Group, S. 706, 2045 Franklin St., Denver, CO 80205.

ORTHOPEDIC SURGEON, Board Certified, needed at Livermore Veterans Hospital. Ideal living and good climate. Salary dependent on experience and qualifications. Contact: Byron V. Whitney, MD, FACS, Chief of Surgical Service, Livermore VA Hospital, Livermore, CA 94550, Telephone (415) 447-2560, ext. 213.

CARDIOVASCULAR SURGEON — THORACIC BOARD CERTIFIED—Excellent position available for assistant in busy cardiovascular surgical practice in Southern California. Excellent salary and benefits. Box 9444, Western Journal of Medicine, 731 Market St., San Francisco, CA 94103.

STAFF PSYCHIATRIST—Community based total health care program. Team approach is used to provide full range of direct and indirect services to rural and urban communities. Located in the Central Valley close to San Francisco, Los Angeles, ocean, and the mountains. Contact: J. Frank James, MD, 515 South Cedar Ave., Fresno, CA 93702; (209) 488-3747.

PHYSICIAN—IMMEDIATE OPENING IN SPECIAL CLINICS, Fresno County Department of Health. Wide ranges of clinical, public and rural health activities. California license required before contract. Public health interest, experience, training desirable. Spanish fluency valuable. Contract range $37,800-$40,950. Write Donald T. Rice, MD, 515 South Cedar, Fresno, California 93702, or call (209) 488-3953 collect.

INTERNIST, FAMILY PRACTITIONER, PEDIATRICIAN—Multi-specialty Group located upper Mojave Desert community of 32,000 population. Great outdoor recreation nearby and big city activities within 2 hours. Contact Don Lake, Admin., 1111 N. China Lake Blvd., Ridgecrest, CA 93555, or Phone (417) 446-4571.

5-MAN CLINIC in city of 9,000 needs OB-GYN, PED. and GP. Incorp. group/all benefits. Excellent location, climate, recreation. Contact W. K. Kucera, MD., 1202 E. Jackson, Riverton, WY 82501. Phone (307) 856-2281.

CARDIOLOGIST-INTERNIST wanted to join young progressive internist—subspecialty (Cardiology, Endocrinology, Hematology—Oncology) group in attractive central California community of 60,000, near coast. New offices across from the major hospital with new ICU-CCU. Non-invasive and partial invasive studies available. Corporate benefits. Respond with Curriculum Vitae to Box 9445, Western Journal of Medicine, 731 Market St., San Francisco, CA 94103.

OB-GYN, PULMONARY INTERNIST, GASTROENTEROLOGIST AND ENDOCRINOLOGIST: presently being sought by the Billings Clinic, Billings, Montana. A unique opportunity to join a vigorous 43-physician multispecialty group. Full partnership in two years. Contact: Paul V. Hoyer, MD, Medical Director, P.O. Box 2555, Billings, Montana 59103; Phone (406) 252-4141.

ORTHOPEDIST: Board certified or board eligible, for large multispecialty group. Department currently consists of seven orthopedists. Department and area expanding. Edward H. Start, MD, Chief of Orthopedics, The Permanente Clinic, 5055 North Greeley Ave., Portland, Oregon 97217.

(Continued on Page 34)

THE STATE OF CALIFORNIA
SEEKS

CONSULTANT/ MEDICAL EXAMINER

Department of Industrial Relations

Conduct medical examinations for industrial injury cases and evaluate workers' compensation liability as relates to California Workers' Compensation Law. Position requires 3 years experience in industrial medicine including traumatic or orthopedic surgery and a California license. See salary below.*

MEDICAL OFFICER

State Personnel Board

Advise staff on the medical phases of the personnel program within the State civil service system and develop and implement a pre-employment physical examination program. Position requires 5 years experience in the practice of medicine and a California license. See salary below.*

*Annual salary up to $40,240.

For additional information write in complete confidence to:

M. Carlos Solis
STATE PERSONNEL BOARD
801 CAPITOL MALL
SACRAMENTO, CA 95814

California State Government is an Equal Opportunity Employer

FAMILY MEDICINE

is alive and well and thriving in Kaukauna, Wisconsin—additional family physicians are being sought. Good opportunity for partnership with modern clinic building or other arrangements can be made. Ideal Northeastern Wisconsin location with excellent cultural and recreation facilities. Offers good opportunity for unlimited general practice with back up of specialties if necessary. Inquiries and visits welcomed. Contact Administrator,

KAUKAUNA COMMUNITY HOSPITAL
Kaukauna, Wisconsin 54130
or phone collect (414) 766-4211

WILSHIRE PERSONNEL SERVICE

G.P.s 3 OPENINGS
1—Spanish Speaking
1—Full or Part-time
1—Locum Tenens

ORTHO
Full or Part-time

OB-GYN
Growing Residential Area

INTERNIST
Several Openings

Sub-Specialties Also Desired

Many Additional Listings in Los Angeles and Orange Counties

(213) 483-6253

or mail C. V. to

1930 Wilshire Blvd., No. 1417
Los Angeles, CA 90057

10 a.m. to 6 p.m.

CALIFORNIA
MEDICAL ASSOCIATION

105th Annual Session
AND
Western Scientific Assembly

February 6-11, 1976 • Hyatt Regency and Sheraton-Palace Hotels, San Francisco

Registration Opens Friday, February 6, 7:45 a.m. at Both Hotels

(Shuttle bus service will be provided between the two meeting hotels, February 6-9)

SCIENTIFIC SESSIONS & EXHIBITS	**Begin Friday Morning, February 6 Conclude Monday, February 9 Hyatt Regency Hotel**	**HOUSE OF DELEGATES**	**Opening Session Saturday, February 7 Closing Session Wednesday, February 11 Sheraton-Palace Hotel**

APPLICATION FOR HOTEL ACCOMMODATIONS

Fill in the form below **completely** for room accommodations at the CMA's 1976 Annual Session.

Your reservation request should include the definite date and hour of your arrival and departure.

All reservations, except for suites, must be made through CMA Housing Bureau, 1390 Market Street, Suite 201, San Francisco, CA 94102 **by January 1, 1976.**

All SUITE reservations must be cleared through the CMA Convention Office, San Francisco. If you are requesting a suite, direct your requests to: CMA Convention Office, 731 Market Street, San Francisco 94103.

Cancellations: Please notify The Housing Bureau of all cancellations.

Changes: All other changes are to be made directly with the hotel at all times.

Send to: CMA Housing Bureau
1390 Market Street, Suite 201
San Francisco, California 94102

HOTEL	SINGLES	TWINS or DOUBLES	SUITES
Sheraton-Palace (official family only)	$25-31	$29-35	$ 65
Hyatt Regency	$26-48	$36-58	$ 75 & up
Hyatt Union Square	$39-51	$49-61	$101 & up

Please reserve the following accommodations for the CMA's 1976 Annual Session:

Please Indicate Preference:

Hotel: First Choice _____ Second _____ Third _____

Accommodations: Single $_____ Double $_____ Twin $_____

Suites: Parlor and 1 Bedroom $_____ Parlor and 2 Bedrooms $_____

Arrival (date) _____ Hour _____ a.m. p.m. Departure (date) _____ Hour _____ a.m. p.m.

The name and address of each hotel guest must be listed. Include names and addresses of **each** person in a double or twin-bedded room, and names and addresses of **all other persons** for whom you are requesting reservations.

Your Name _____

Address _____

City and State _____ Zip Code _____

ADDITIONAL OCCUPANTS:

_____

_____

_____

(Continued from Page 32)

PHYSICIANS WANTED

SURGEONS, FAMILY PRACTICE, and INTERNAL MEDICINE physicians should consider McCook, Nebraska as an excellent area for relocation. McCook has a new, 56-bed, accredited hospital that serves 15-20,000 people. McCook has 4 lakes within 60 miles for fishing and recreational purposes and is only 2 air hours from Denver and Omaha. For complete information, contact: Ken Noteboom, Administrator, Community Hospital, P.O. Box 310, McCook, Nebraska 69001.

SURGEON for trade area of 45,000. Modern 56-bed hospital with full time anesthesiologist. General Practitioners now doing the surgery. Appointment available to teaching facility, University Nebraska School of Medicine. Boating, Fishing, 20 minutes away. Cabin in Colorado Rockies available for weekends, etc. Contact Don Morgan, MD, Bob Phillips, MD, Box 491, McCook, Nebraska 69001 or call collect (308) 345-1480.

FAMILY PHYSICIAN for 3rd member of group. Offices soon going up connecting to 1-year-old 56-bed hospital with direct wire to University for EKG and EEG. 8 GP's share emergency call. Appointment available to teaching faculty of the University of Nebraska School of Medicine. Boating, Fishing only 20 minutes away. Cabin in Colorado Rockies available for weekends, etc. We have even started our own private game preserve with a herd of Buffalo. Partnership available. Contact Don Morgan, MD or Bob Phillips, MD, Box 491, McCook, Nebraska 69001 or call collect (308) 345-1480.

DEPUTY DIRECTOR, CHILD HEALTH AND DISABILITY PREVENTION PROGRAM, San Joaquin County. Administrative and clinical responsibility for program to examine children to detect early childhood disabilities. Qualifications: MD plus one year experience providing, administering or planning health services for children. $31,308-38,040 per annum. Starting salary negotiable. Numerous fringe benefits. Reply to S. O. Smelsey, MD, 1601 E. Hazelton Ave., P.O. Box 2009, Stockton, or call collect (209) 466-6781.

OREGON — EMERGENCY PHYSICIAN positions available with an established group at a hospital in eastern Oregon, 50 minutes from Boise, Idaho. Two hours from skiing at Sun Valley. Fee-for-service. Paid malpractice insurance. Contact: Administrator, Emergency Physicians, 897 MacArthur Blvd., San Leandro, CA 94577 or call (415) 638-3979.

ONCOLOGY FELLOWSHIP POSITION—Immediate Opportunity. Unexpected opening for a first or second year oncology fellow available at University of California, San Francisco. At least 2 years of previous internal medicine training are required. The program consists of in-patient care on the Cancer Research Institute, clinical outpatient experience, cooperative chemotherapy group participation and clinical investigation. Salary according to NIH guidelines with supplementation for dependents. For further information contact Dr. Michael A. Friedman at the Cancer Research Institute, University of California, San Francisco, CA 94143. (415) 666-3278. An Equal Opportunity/Affirmative Action Employer.

TWO FULL-TIME PHYSICIANS for family practice located in Torrance, California. Salary negotiable. Please contact Mr. Russell at (213) 542-3583.

PSYCHIATRISTS: Openings expected soon in University affiliated teaching unit. Salary flexible, liberal benefits including malpractice coverage. Contact Matthew Ross, MD, VA Hospital, Long Beach, CA 90801. Equal opportunity employer.

UPPER MIDDLE-CLASS HILL COMMUNITY, next to Berkeley, has no physician. Within 10 minutes of 3 hospitals, 30 minutes to UC Medical Center. Community needs GP, Family Practice, or other physician with broad interest. Contact Hercules D. Morphopoulos at 267 Arlington Ave., Berkeley, CA 94707; (415) 525-2881.

NEONATOLOGIST-DEVELOPMENTALIST for position on the faculty of the Department of Pediatrics, Harbor General Hospital Campus of the UCLA School of Medicine. Must be interested in basic perinatal research. Clinician to join two full-time faculty in neonatal medicine. Send curriculum vitae to Donald W. Thibeault, MD, Chief, Division of Neonatology, Harbor General Hospital, 1000 W. Carson Street, Torrance, CA 90509. We are an affirmative action employer.

PRACTICE AVAILABLE

F.P., internal medicine, San Francisco peninsula, 30 years same location, $82,000 gross, $58,000 net, retiring Dec. 1975, will turn over practice free of charge, office fully equipped, hospital 1 mile, rent $500/month, 1,600 sq. ft., suitable for 2 physicians. Write Box 9428, Western Journal of Medicine, 731 Market St., San Francisco, CA 94103.

FAMILY PRACTICE PHYSICIANS WANTED

KNOX CITY—KNOX COUNTY, TEXAS: This small community of 1,800 people with a surrounding county population of 6 other small communities with 5,000 residents is in an "emergency" need of one more GP. An association with another GP is available in an excellent clinic with all services located directly across the street from a fully staffed, 1st rate, 28-bed hospital. No financial investment or expenses incurred from the moment initial contact is made. From the first phone call till you see your first patient, your expenses become ours. We'll even come to see you to explain what we have! Hunting, fishing, golf, a "personal" practice and a chance to give your kids an opportunity to know what a "free" life really is. "We don't lock our doors and we don't lock our cars." We know they'll be safe through the night! At least give us a chance to tell you about us. **Call collect; Glen Rumley, Adm. Knox County Hospital, Knox City, Texas. Phone (817) 658-3535. "If you don't like us, you don't like people!"**

MEDICAL BUILDING

DOCTORS! NURSES! ADMINISTRATORS! HOSPITAL! — Nursing Home — Suitable for Medical Clinic, Rest Home or Board and Care Home. An A-1 perfect miniature Hospital fully equipped—21 beds, Nurses Station. Everything in excellent condition. For more information on this property call Knight Realty, San Francisco, (415) 661-5700.

(Continued on Page 41)

How many of your patients know what vitamin A and vitamin C are?

But they do know what vegetables and fruits are.

The foods above have several nutrients in common. The principal ones are vitamins A and C, important for building body resistance to infection. Because citrus fruits, leafy greens, broccoli, carrots, cabbage and others provide these nutrients, these kinds of foods are classified as the Vegetable & Fruit Group in the U.S. Department of Agriculture's Four Food Groups system.

Some physicians counsel patients in terms of nutrients. Which is easier for them to understand—foods or nutrients?

For attractive, color copies of the Four Food Groups guide for your patients, write: Dairy Council of California, Box 28F, Sacramento, CA 95825.

Dairy Council of California

The Four Food Groups—milk, meat, vegetables and fruits, breads and cereals—a practical guide to good nutrition.

Relief from her arthritic pain

Darvocet-N® 100

100 mg. propoxyphene napsylate and
650 mg. acetaminophen

contains no aspirin

Darvon® Compound-65

65 mg. propoxyphene hydrochloride, 227 mg. aspirin,
162 mg. phenacetin, and 32.4 mg. caffeine

contains aspirin

for mild to moderate pain

See summary of prescribing information on adjoining page.

3-

THE NATURAL WAY

For more than thirty years PREMARIN (Conjugated Estrogens Tablets, U.S.P.) has been prepared with natural equine estrogens exclusively—without synthetic estrogen supplements. For more than thirty years it has provided the complete estrogen complex in the proportions found in its natural source. And for more than thirty years PREMARIN has enjoyed an unparalleled record of clinical efficacy and acceptance.

PREMARIN. The only estrogen preparation available that contains natural estrogens exclusively and also meets all U.S.P. specifications for conjugated estrogens. Assurance of quality for you and your patients.

PREMARIN . . . naturally.

BRIEF SUMMARY
(For full prescribing information, see package circular.)
PREMARIN®
(Conjugated Estrogens Tablets, U.S.P.)

Indications: Based on a review of PREMARIN Tablets by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications for use as follows:
Effective: As replacement therapy for naturally occurring or surgically induced estrogen deficiency states associated with: the climacteric, including the menopausal syndrome and postmenopause; senile vaginitis and kraurosis vulvae, with or without pruritus.
"Probably" effective: For estrogen deficiency-induced osteoporosis, and only when used in conjunction with other important therapeutic measures such as diet, calcium, physiotherapy, and good general health-promoting measures. Final classification of this indication requires further investigation.

Contraindications: Short acting estrogens are contraindicated in patients with (1) markedly impaired liver function; (2) known or suspected carcinoma of the breast, except those cases of progressing disease not amenable to surgery or irradiation occurring in women who are at least 5 years postmenopausal; (3) known or suspected estrogen-dependent neoplasia, such as carcinoma of the endometrium; (4) thromboembolic disorders, thrombophlebitis, cerebral embolism, or in patients with a past history of these conditions; (5) undiagnosed abnormal genital bleeding.
Warnings: Estrogen therapy should not be given to women with recurrent chronic mastitis or abnormal mammograms except, if in the opinion of the physician, it is warranted despite the possibility of aggravation of the mastitis or stimulation of undiagnosed estrogen-dependent neoplasia.

The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, retinal thrombosis, cerebral embolism and pulmonary embolism). If these occur or are suspected, estrogen therapy should be discontinued immediately.

Estrogens may be excreted in the mother's milk and an estrogenic effect upon the infant has been described. The long range effect on the nursing infant cannot be determined at this time.

Hypercalcemia may occur in as many as 15 percent of breast cancer patients with metastases, and this usually indicates progression of bone metastases. This occurrence depends neither on dose nor on immobilization. In the presence of progression of the cancer or hypercalcemia, estrogen administration should be stopped.

A statistically significant association has been reported between maternal ingestion of diethylstilbestrol during pregnancy and the occurrence of vaginal carcinoma in the offspring. This occurred with the use of diethylstilbestrol for the treatment of threatened abortion or high risk pregnancies. Whether or not such an association is applicable to all estrogens is not known at this time. In view of this finding, however, the use of any estrogen in pregnancy is not recommended.

Failure to control abnormal uterine bleeding or unexpected recurrence is an indication for curettage.

Precautions: As with all short acting estrogens, the following precautions should be observed:

A complete pretreatment physical examination should be performed with special reference to pelvic and breast examinations.

To avoid prolonged stimulation of the endometrium and breasts in climacteric or hypogonadal women, estrogens should be administered cyclically (3 week regimen with 1 week rest period—withdrawal bleeding may occur during rest period).

Because of individual variation in endogenous estrogen production, relative overdosage may occur which could cause undesirable effects such as abnormal or excessive uterine bleeding, mastodynia and edema.

Because of salt and water retention associated with estrogenic anabolic activity, estrogens should be used with caution in patients with epilepsy, migraine, asthma, cardiac, or renal disease.

If unexplained or excessive vaginal bleeding should occur, reexamination should be made for organic pathology.

Pre-existing uterine fibromyomata may increase in size while using estrogens; therefore, patients should be examined at regular intervals while receiving estrogenic therapy.

The pathologist should be advised of estrogen therapy when relevant specimens are submitted.

Because of their effects on epiphyseal closure, estrogens should be used judiciously in young patients in whom bone growth is incomplete.

Prolonged high dosages of estrogens will inhibit anterior pituitary functions. This should be borne in mind when treating patients in whom fertility is desired.

The age of the patient constitutes no absolute limiting factor, although treatment with estrogens may mask the onset of the climacteric.

Certain liver and endocrine function tests may be affected by exogenous estrogen administration. If test results are abnormal in a patient taking estrogen, they should be repeated after estrogen has been withdrawn for one cycle.

Adverse Reactions: The following adverse reactions have been reported associated with short acting estrogen administration:
nausea, vomiting, anorexia
gastrointestinal symptoms such as abdominal cramps and bloating
breakthrough bleeding, spotting, unusually heavy withdrawal bleeding (See DOSAGE AND ADMINISTRATION)
breast tenderness and enlargement
reactivation of endometriosis
possible diminution of lactation when given immediately postpartum
loss of libido and gynecomastia in males
edema
aggravation of migraine headaches
change in body weight (increase, decrease)
headache
allergic rash
hepatic cutaneous porphyria becoming manifest

Dosage and Administration: PREMARIN should be administered cyclically (3 weeks of daily estrogen and 1 week off) for all indications except selected cases of carcinoma and prevention of postpartum breast engorgement.

Menopausal Syndrome—1.25 mg. daily, cyclically. Adjust dosage upward or downward according to severity of symptoms and response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control.

If the patient has not menstruated within the last two months or more, cyclic administration is started arbitrarily. If the patient is menstruating, cyclic administration is started on day 5 of bleeding. If breakthrough bleeding (bleeding or spotting during estrogen therapy) occurs, increase estrogen dosage as needed to stop bleeding. In the following cycle, employ the dosage level used to stop breakthrough bleeding in the previous cycle. In subsequent cycles, the estrogen dosage is gradually reduced to the lowest level which will maintain the patient symptom-free.

Postmenopause—as a protective measure against estrogen deficiency-induced degenerative changes (*e.g.* osteoporosis, atrophic vaginitis, kraurosis vulvae)—0.3 mg. to 1.25 mg. daily and cyclically. Adjust dosage to lowest effective level.

Osteoporosis (to retard progression)—usual dosage 1.25 mg. daily and cyclically.

Senile Vaginitis, Kraurosis Vulvae with or without Pruritus—0.3 mg. to 1.25 mg. or more daily, depending upon the tissue response of the individual patient. Administer cyclically.

How Supplied: PREMARIN (Conjugated Estrogens Tablets, U.S.P.)

No. 865—Each *purple* tablet contains 2.5 mg., in bottles of 100 and 1,000.

No. 866—Each *yellow* tablet contains 1.25 mg., in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 867—Each *red* tablet contains 0.625 mg., in bottles of 100 and 1,000.

No. 868—Each *green* tablet contains 0.3 mg., in bottles of 100 and 1,000. **7352**

PREMARIN®

BRAND OF CONJUGATED ESTROGENS TABLETS, U.S.P.

CONTAINS ONLY NATURAL ESTROGENS ...NO SYNTHETICS OR SUPPLEMENTS

Ayerst.

AYERST LABORATORIES
New York, N.Y. 10017

DYAZIDE®

Trademark

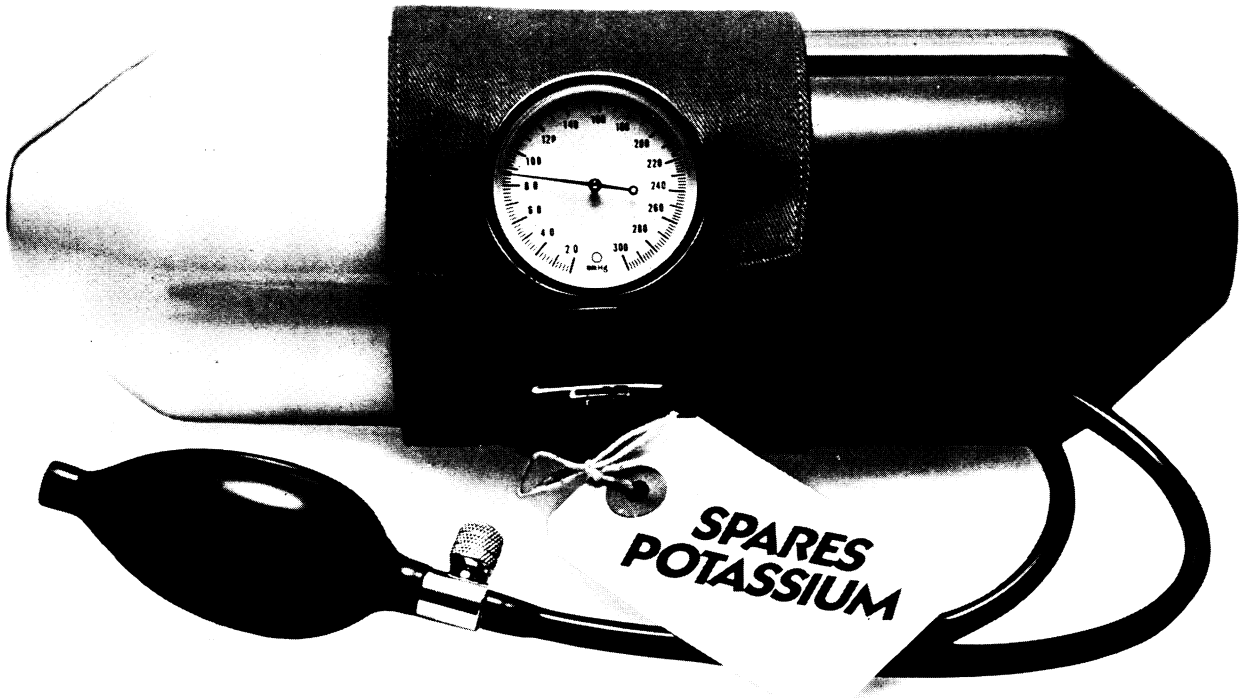
Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F) and 25 mg. of hydrochlorothiazide.

MAKES SENSE

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

FOR LONG-TERM CONTROL OF HYPERTENSION*

Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

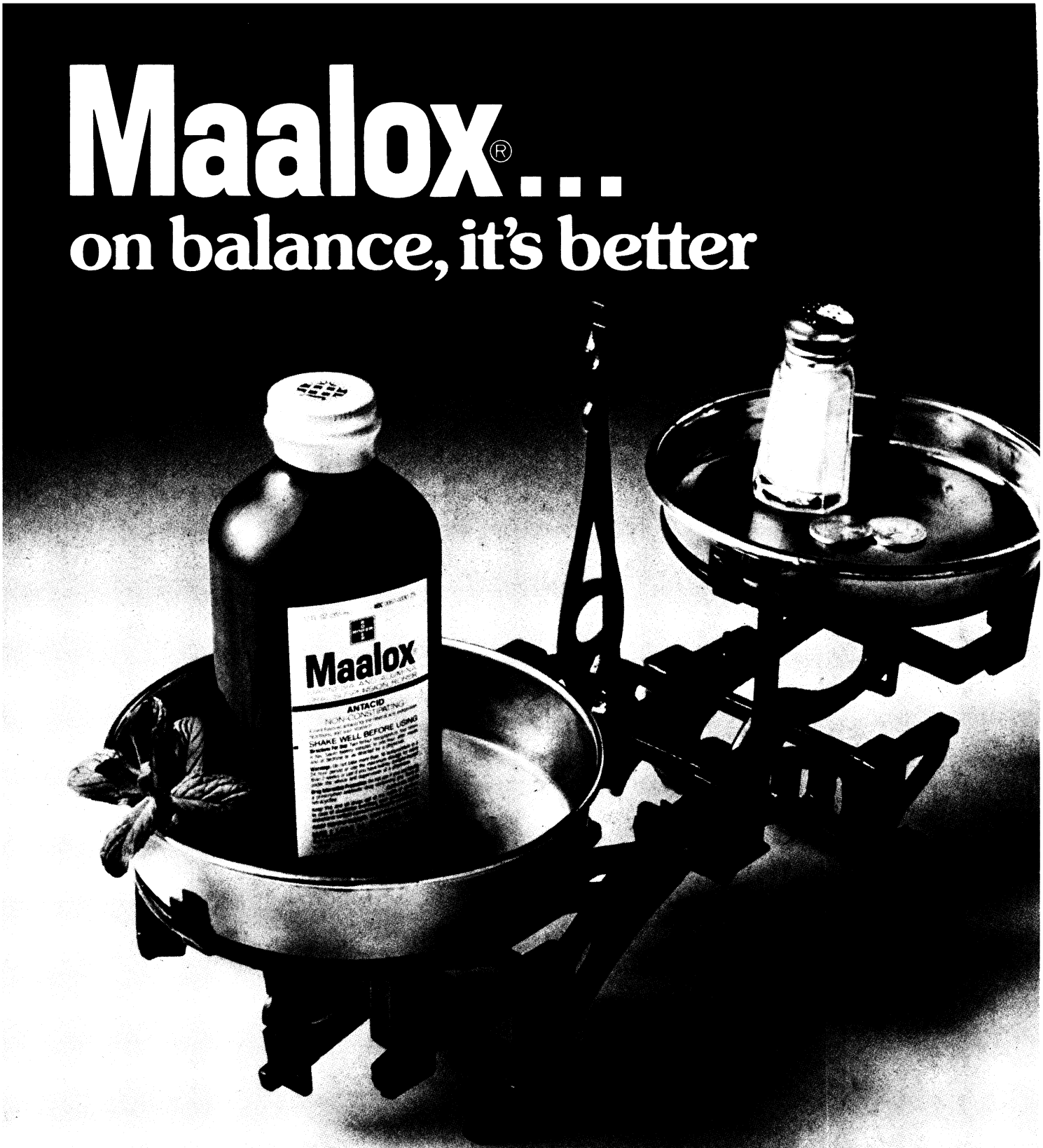
Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Maalox®...
on balance, it's better



- **more effective**—49% more acid neutralizing capacity than the next leading antacid.*
- **greater patient acceptance**—over 25 years' experience with millions of patients.
- **less costly**—50¢ less per bottle than the next leading antacid.
- **less sodium**—36% less sodium than the next leading antacid.

Minty Maalox. Well tolerated, month after month...year after year.

*per minimum recommended dose.

ROER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034